JANSSEN BIOADVANCE®

Patient Enrolment, Rx & Consent Form

Tremfya® (guselkumab) | Tremfya® One-Press®

PLEASE SEND COMPLETED FORM TO YOUR BIOADVANCE® COORDINATOR

1. JANSSEN BIOADVANCE® COORDINATOR INFORMATION

NAME: _____ FAX: _____

EMAIL ADDRESS: _____ PHONE: _____

2. PATIENT INFORMATION

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____

DATE OF BIRTH (MM/DD/YYYY) _____ LANGUAGE PREFERENCE: ☐ ENGLISH ☐ FRENCH

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

HEALTH CARD NUMBER _____ PATIENT GENDER: ☐ FEMALE ☐ MALE

PHONE _____ EMAIL ADDRESS _____

CAN WE LEAVE A MESSAGE AT THIS PHONE NUMBER? ☐ YES ☐ NO

3. OFFICE INFORMATION

PHYSICIAN NAME _____

NURSE NAME _____

HOSPITAL/CLINIC NAME _____ ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PHONE _____ FAX _____

EMAIL ADDRESS _____

DESIGNEE NAME (IF DIFFERENT THAN ABOVE) _____ DESIGNEE PHONE _____

4. PRESCRIBING PHYSICIAN SECTION†

INDICATION

☐ PSORIATIC ARTHRITIS
☐ PLAQUE PSORIASIS

Other directives/ notes: _____

DOSAGE FORM

☐ TREMFYA®
pre-filled syringe guselkumab injection
DIN 02469758
100 mg/mL subcutaneous

☐ TREMFYA ONE-PRESS®
patient-controlled injector guselkumab injection
DIN 02487314
100 mg/mL subcutaneous

FREQUENCY

INITIAL WEEKS
☐ 0 WEEKS ☐ 4 WEEKS

AND/OR

☐ MAINTENANCE: Q 8 WEEKS
REPEATS _____

REIMBURSEMENT

5. PSORIASIS ASSESSMENT DETAILS

BSA %: _____ PASI: _____ DLQI: _____

☐ FACE ☐ HANDS ☐ FEET ☐ GENITALS

6. PSORIATIC ARTHRITIS ASSESSMENT

_____ # Swollen joints
_____ DAS28 Score
_____ HAQ Score
☐ Radiographic evidence of PsA

7. TUBERCULOSIS EVALUATION

☐ PENDING
☐ NEGATIVE RESULT DATE _____
☐ COMMENTS _____

8. PREVIOUS THERAPIES

PSORIASIS		START/STOP DATES/COMMENTS
☐ Methotrexate	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Acitretin	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Cyclosprine	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Topicals	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Phototherapy	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	

PSORIATIC ARTHRITIS		START/STOP DATES/COMMENTS
☐ Methotrexate	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Leflunomide	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Sulfasalazine	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	

9. PHYSICIAN

† Effective date. Orders expire one year from the date of signature.
Prescriber certification: I certify that this prescription is an original prescription and this pharmacy is the only receiver. The original will not be reused.

SIGNATURE _____ COLLEGE LICENSE #: _____

DATE: _____

10. PATIENT

☐ **I have read and understood the Patient Consent, detailed on page 2, and agree to the collection, use and disclosure of my personal information in accordance with these terms.**

PATIENT SIGNATURE _____ DATE: _____

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MEMBER OF INNOVATIVE MEDICINES CANADA

Janssen

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PATIENT CONSENT

I agree to permit my healthcare provider(s), including physician(s) or nurse(s), to disclose my personal information to the Janssen BioAdvance® Coordinator assigned to managing my patient file, or his/her replacement (where applicable) (the "BAC") in order to facilitate my enrolment in the BioAdvance® Program and facilitate the obtaining of my first TREMFYA®/ TREMFYA ONE-PRESS® prescription, and I agree that the BAC can contact me for such purposes. Personal information may include my name, address, date of birth, phone numbers and any other personal information, including my personal health information, such as my diagnosis and the information included on my prescription or on this Patient Enrolment, Rx & Consent Form (the "Consent Form").

My personal information will not be used or disclosed by the BAC for any purpose other than those described above unless information that identifies me directly is first removed or as is permitted or required by law. In addition, once I have been contacted by the BAC, if I elect to benefit from the services provided by the BAC, I will be required to sign another Consent Form with respect to the collection, use and disclosure of my personal information by the BAC.

I understand that:

- I do not have to sign this Consent Form, but if I do not, my healthcare provider(s) will not be able to disclose my personal information to the BAC and I will not be able to benefit from the services provided by the BAC (unless I contact the BAC directly myself);
- The medical treatment provided by my healthcare provider(s) will not be impacted by whether I sign this Consent Form or not;
- I may revoke (take back) this authorization at any time by mailing or faxing signed letter(s) of revocation to my healthcare provider(s), but if I do so, I will be unable to benefit from the services provided by the BAC;
- Revoking this authorization will prohibit disclosure of my health information by my healthcare provider(s) after the date my letter of revocation is received and processed, but will not affect the use or disclosure of information already received by the BAC;
- I am entitled to a copy of this Consent Form;
- If I want to access my patient file maintained by the BAC and/or make changes or corrections to it, I may do so by written request to the currently active BAC.

Please see Product Monograph for full prescribing information for TREMFYA®/TREMFYA ONE-PRESS®.
For more information, please contact Janssen Inc. Medical Information at 1-800-567-3331.