Bristol Myers Squibb™
Patient Support Program >
Your patient. Our commitment.

PATIENT ENROLMENT FORM

ONCE-DAILY
SOTYKTU™
deucravacitinib tablets

PATIENT SUPPORT PROGRAM FOR SOTYKTU™
Please fax the enrolment form to your Case Manager _____ (fillable by Case Manager).
1-833-764-2158 | For general inquiries, please call **1-833-764-2157**.

Fields denoted by an asterisk (*) are mandatory.

The Bristol Myers Squibb Patient Support Program is available for adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

SECTION 1: Patient Information

Last name*: | **First name*:**

Preferred language: ☐ E ☐ F ☐ Other: _____ | **Date of birth (dd/mmm/yyyy):**

Health card #: | **Gender:** ☐ M ☐ F ☐ Other: _____

Address:

City/Town: | **Province:**

Postal code: | **Preferred phone #*:**

Email: | **Insurance coverage:** ☐ Public ☐ Private ☐ Dual ☐ None

Caregiver Information

Name: | **Preferred phone #:**

Clinical Information

Assessment details:

PASI score: _____
DLQI score: _____
BSA %: _____

Significant involvement of:
☐ Face ☐ Hands
☐ Feet ☐ Genitals

Tuberculosis (TB) evaluation
☐ To be coordinated by the Program
☐ TB Quantiferon Gold or
☐ Mantoux Skin
☐ Not required
☐ Negative result
Date (dd/mmm/yyyy): _____
☐ Pending
☐ Positive result
Date (dd/mmm/yyyy): _____

Allergies: _____

Treatment history:

Select therapies taken by patient and indicate reason for stopping if applicable: (NA=no access, IR=inadequate response, IN=intolerance, CI=contraindication)

	NA	IR	IN	CI
☐ Methotrexate		☐	☐	☐
☐ Acitretin		☐	☐	☐
☐ Cyclosporine		☐	☐	☐
☐ Phototherapy	☐	☐	☐	☐
☐ Topicals		☐	☐	

Other information

SECTION 2: Patient Consent

PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND THE TERMS OF THE AGREEMENT IN **SECTIONS 5 AND 6**.

I consent to enrol in the Program

Signature of patient or legal representative*:

Date (dd/mmm/yyyy):

☐ **Check box where consent provided through substitute decision maker**

(print name of substitute decision maker):

SECTION 3: Prescribing Physician Information

Last name*: | **First name*:**

Clinic name*: | **Office contact:**

Address*:

City*: | **Province*:** | **Postal code*:**

Office phone #*: | **Office fax #*:**

Email*:

STAMP HERE

SECTION 4: Prescription

SOTYKTU is being prescribed for the treatment of adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

Last name: _____ First name: _____

Patient received SOTYKTU samples? ☐ Yes / ☐ No

Date given (dd/mmm/yyyy): _____

SOTYKTU 6 mg PO QD x 30 days: _____ Refills

☐ **I confirm that I have reviewed the SOTYKTU Product Monograph and I am prescribing this medication for this patient in accordance with the intended use as outlined therein.**

☐ **Patient is medically clear to start therapy.**

Physician license number*: _____

Physician's signature*:

Date (dd/mmm/yyyy):

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SECTION 5: Patient Consent

PROGRAM ENROLMENT AND PATIENT PRIVACY CONSENT

Your Patient Support Program for SOTYKTU (which we will refer to as the **"Program"**) provides patients who have been prescribed SOTYKTU with educational and therapy support services.

Your personal information may be collected, used, or disclosed for Program purposes outlined above and for related purposes outlined in the *Use and disclosure of your personal information* section below. **This consent is required to have access to the services being provided by the Program**.

☐ By checking this box, I authorize the Administrator to communicate with me through email for purposes related to the Patient Support Program for SOTYKTU. I understand that email may not be the most secure means of communication and as such, the Administrator will not include sensitive health information in any emails used to communicate with me. Such emails may, however, identify me as an individual registered with the Program. I may withdraw my consent to receive emails by contacting the Administrator.

I further understand that my consent is required to have access to the services being provided by the Program.

COLLECTION AND USE OF INFORMATION FOR MARKET RESEARCH OR HEALTH OUTCOMES RESEARCH (OPTIONAL)

From time to time, the Administrator or BMS, as applicable, may (i) retain the services of third-party market research firms to better understand the patient experience of individuals enrolled in the Program or make improvements to the Program (**"Market Research"**) or (ii) conduct Health Outcomes Research to provide information for insurers, public health plans, regulators, and other interested stakeholders for products like SOTYKTU (**"Health Outcomes Research"**). At such time, the Administrator may reach out to you to provide consent to participate in such Market Research or Health Outcomes Research, as applicable. Participation in any Market Research or Health Outcomes Research is voluntary, and the patient may withdraw consent at any time by notifying the Administrator using the information outlined in the Administrator Contact Information section below.

Your consent to participate in any Market Research or Health Outcomes Research is not required to have access to the services being provided by the Program.

VERBAL PATIENT CONSENT*

To be completed by Health Care Provider (if applicable).
Verbal consent obtained by Health Care Provider:

Last Name: **First Name:**

The patient has given consent to (please check the boxes that apply):

☐ **Program Enrolment and Patient Privacy Consent (required to enrol in the program)**

☐ By checking this box, I authorize the Administrator to communicate with me through email for purposes related to the Patient Support Program for SOTYKTU. I understand that email may not be the most secure means of communication and as such, the Administrator will not include sensitive health information in any emails used to communicate with me. Such emails may, however, identify me as an individual registered with the Program. I may withdraw my consent to receive emails by contacting the Administrator.

Patient name: **Date (dd/mmm/yyyy):**

Health Care Provider Signature:*

SECTION 6: Enrolment And Consent Form For Your Patient Support Program For Sotyktu By Bristol Myers Squibb

PROGRAM ENROLMENT AND PATIENT PRIVACY CONSENT
BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOUR PERSONAL INFORMATION WILL BE COLLECTED, USED, AND/OR SHARED FOR THE PURPOSES OUTLINED BELOW.

About Your Patient Support Program for SOTYKTU

The ***Patient Support Program for*** SOTYKTU (which we will refer to as the **"Program"**) is a customer service program that provides patients like you (**"you"** or **"your"** refers to you or your child, as the case may be) who have been prescribed SOTYKTU with educational and therapy support services, including:

- Education and training about the SOTYKTU treatment;
- Cost reimbursement services, which may include assistance in reviewing eligibility for and coordinating reimbursement and/or financial assistance with your private insurers or any applicable provincial health plan, out of pocket costs; and
- Therapy administration services such as coordinating delivery of SOTYKTU to you and assistance with the administration of SOTYKTU (collectively we will refer to them as the **"Support Services"**).

Your personal information may be collected, used, or disclosed for Program purposes outlined above and for related purposes outlined in the *Use and disclosure of your personal information* section below.

Who is running this Program?

The Program is sponsored by Bristol Myers Squibb (**"BMS"**) and is administered on behalf of BMS by Innomar Strategies, a third-party company that provides client-focused services and patient support programs (we will refer to Innomar Strategies as the **"Administrator"**). If Innomar Strategies ceases to be the Administrator, BMS may appoint a replacement Administrator to administer the Program. In such a circumstance, your personal information may be transferred to and used by the replacement Administrator in the manner described on this form, to continue to administer the Program and provide you with Support Services.

Collection of your personal information

The Administrator may collect your personal information directly from you and your authorized representatives (e.g., a substitute decision maker), doctors, nurses, pharmacists, private insurance companies, public payers and any other healthcare provider or payer that may possess the necessary information. Generally, "personal information" refers to:

- your name, address, phone number, email address, date of birth;
- details of your medical conditions, medical history, medical treatments, and drug prescription information; and
- financial information such as your insurance coverage.

The Administrator will only collect the minimum amount of personal information necessary to administer the Program or provide you with the Support Services.

Use and disclosure of your personal information

The Administrator (and its authorized representatives and agents) may collect, use and/or share your personal information to:

- Administer the Program;
- Provide you with the Support Services;
- Determine your eligibility for the Program and Support Services, including verifying insurance coverage for SOTYKTU and/or otherwise arranging for reimbursement for SOTYKTU;
- Personalize the Program and Support Services to your specific circumstances;
- Provide you with materials relating to your medication, treatment and the Program;
- Contact you to inform you of changes in the Program and Support Services;
- Obtain your feedback on the Program and Support Services;
- Evaluate and report patient outcome data associated with the administration of SOTYKTU;
- Perform internal evaluation and assessments of the Program and Support Services, including limited market research; and
- Undertake safety monitoring, reporting, and auditing and responding to enquiries or issues in relation to medication, or as otherwise may be required by law.

The Administrator may also share your personal information with other health professionals in your circle of care (e.g., your doctor, pharmacist) and your public/private health insurance provider to: enrol you into the Program; administer the Program; to provide you with the Support Services; in relation to your medication, treatment, medical condition, or other health related reasons; or as otherwise may be required for legal or regulatory purposes.

BMS's access or use of your information

The Administrator, in the normal course of administering the Program, will not directly share your personal information with BMS or its service providers; however, the Administrator may share your personal information with BMS or its service providers in limited circumstances, including:

- for safety monitoring and regulatory reporting purposes (e.g., reporting an adverse reaction to Health Canada);
- to transfer your personal information to a new Program administrator; or
- to perform audits of the Program to evaluate or improve the Program.

Additionally, BMS may transfer any personal information related to the Program in connection with the sale or transfer of all or a portion of its business or assets or rights in those businesses or assets. Should such a sale or transfer occur, BMS will request that the purchaser use and disclose personal information you have provided through this Program in a manner that is consistent with the purposes disclosed here.

The Administrator may share with BMS de-identified or aggregate data generated from information collected over the course of the Program, which may then be used by BMS for the purposes of:

- developing, evaluating or improving the Program and Support Services (including patient participation and experiences) or the SOTYKTU treatment approaches and implementation;
- financial administration of the Program or Support Services; or
- conducting clinical or marketing research, including future scientific research, regulatory submissions, and publications.

Protection of your personal information

BMS is legally responsible for protecting any personal information collected from you in connection with the Program in accordance with applicable privacy laws.
A copy of the BMS Privacy Policy is available at:
https://www.bms.com/ca/en/privacy-policy.html

Storage of your personal information

The Administrator and/or BMS may transfer, store or process personal information outside Canada. In such circumstances your personal information may be subject to the laws of the foreign country where it is stored, and those other foreign countries may have a different level of legal protection than my country of residence. As a result, in certain circumstances, other foreign governments, courts, law enforcement agencies or regulatory agencies may be entitled to access or collect personal information.

Your personal information will be kept for the duration of your participation in the Program and will thereafter be deleted in accordance with the Administrator's and BMS's document retention policies, subject to legal and regulatory requirements.

Access or correction of your personal information

You may request access to and/or correction of your personal information held by the Administrator by contacting them using the information outlined in the *Administrator Contact Information* section.

Withdrawal from the Program or withdrawal of consent

Your participation in the Program is voluntary. If you choose not to participate, neither your medical treatment nor your insurance coverage eligibility will be impacted. You may refuse to sign the consent form and/ or refuse to consent to the collection, use and disclosure of your personal information, as outlined above. However, if you do not consent to the collection, use and disclosure of your personal information as described in this form, you will not be able to participate in the Program or receive Support Services.

You may cancel your enrolment or revoke your consent at any time by sending a written and signed request to the Administrator using the information outlined in the *Administrator Contact Information* section. Your cancellation will take effect upon receipt of the letter by the Administrator. In such situations, no new personal information will be collected from you, but your personal information will be maintained as required for legal and regulatory purposes, and BMS may continue to use de-identified or aggregated information as described above.

Administrator Contact Information

If you wish to make inquiries or complaints or have other concerns about the collection, use or information of your personal information as part of Program or Support Services, about Administrator's personal information practices, to withdraw your consent, or to request access or correction to your personal information you may contact the Administrator in writing using the following contact information:

Mailing address: 3470 Superior Court, Oakville, ON L6L 0C4
Fax: 1-833-764-2158

The Administrator may need to confirm your identity or request additional details in order to process your request.

BY SIGNING THIS CONSENT FORM:

- I confirm that I have read, fully understand, and consent to the collection, use, and disclosure of my personal information in accordance with the terms outlined in this Patient Privacy Consent Form.
- I understand that I am not required to sign this consent form. If I choose not to consent to the collection use, and disclosure of my personal information, I will not be able to participate in the Program.
- I understand that participation in the Program is not required for me to have access to SOTYKTU.
- I give permission for my healthcare professionals, pharmacies, health insurance providers or payers to share my personal information, including information about prescriptions, medical condition, health, and financial information, with the Administrator or its agents, so that the Administrator may use the personal information to provide the Support Services and administer the Program as described above.
- I understand that telephone calls between me and employees of the Administrator may be monitored or recorded for quality control or training purposes.
- I recognize that my personal information may be transferred and stored outside of Canada.
- I understand that all the information provided to BMS may be shared with its group companies for the purposes outlined in *BMS's access or use of your information* section.
- I understand that BMS may share my personal information with regulatory authorities such as Health Canada or other government agencies in and outside of Canada in the context of reporting any adverse drug events or as otherwise required by law.
- I acknowledge that unless and until revoked, my consent is valid for the duration of my participation in the Program. I accept that even after I withdraw my consent or after I stop participating in the Program my personal information will be maintained as required for legal and regulatory purposes, and BMS may continue to use de-identified or aggregated information as described in *BMS's access or use of your information* section.
- I accept that BMS reserves the right to modify, suspend or terminate the Program or any or all Support Service, or any part thereof, in its sole discretion, including changing third-party service providers. BMS will provide me notice of such changes where required by law.

SOTYKTU (deucravacitinib tablets) is indicated for the treatment of adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. Please consult the Product Monograph at https://www.bms.com/assets/bms/ca/documents/productmonograph/SOTYKTU_EN_PM.pdf for important information on contraindications, warnings, precautions, adverse reactions, interactions, dosing, and conditions of clinical use. The Product Monograph is also available by calling 1-866-463-6267.

CONTACT INFORMATION FOR ADMINISTRATOR Phone: **1-833-764-2157** | Fax: **1-833-764-2158** | Email: **sotyktu@innomar-strategies.com**

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