UCBCares™ Patient Support Program

PrCIMZIA® PATIENT ENROLMENT FORM

cimzia® (certolizumab pegol)

Please fax to **1-877-820-6107** or email **enrolments@ucbcares.ca**

FOR PROMPT ASSISTANCE, CALL THE UCBCARES™ SUPPORT LINE AT **1-800-908-5555**

Patient Information *(To be completed by patient)*

First and Last Name:	Birth Date (YYYY/MM/DD): / /	Sex: ☐ M ☐ F ☐ Prefer not to say
Health Card Number:	Phone (Primary):	Phone (Other):
Street Address:		City:
Province:	Postal Code:	Email:

Patient Acknowledgement ☐ I consent to receive electronic communications related to the Program.

I have read the terms and conditions found on the reverse of this form, understand the services offered by the Program and agree to the collection, use, disclosure and storage of my personal information and personal health information in accordance with those terms and conditions.

Signature of Patient: _____ Date of Signature (YYYY/MM/DD): ____/____/____

Physician Information *(To be completed by physician)*

First and Last Name:	License Number:
Clinic Address:	Phone Number:
Email:	Fax:

Rx PrCIMZIA® (certolizumab pegol) Information

Device: ☐ Pre-filled Syringe (200 mg/mL) DIN 02331675
☐ Autoinjector (200 mg/mL) DIN 02465574

*Please select **diagnosis** and **dosing** as appropriate*

☐ **Rheumatoid Arthritis**

☐ **Psoriatic Arthritis**

☐ **Ankylosing Spondylitis**

☐ **Non-radiographic Axial Spondyloarthritis**

Loading Dose: 400 mg SC at week 0, 2, and 4 followed by:

☐ Maintenance dose: 200 mg SC every 2 weeks for _____ months

☐ Maintenance dose: 400 mg SC every 4 weeks for _____ months

☐ **Psoriasis**

☐ 400 mg SC every 2 weeks for _____ months

☐ **Other** *(specify)*: _____

UCBCares™ Injection services required? ☐ Yes ☐ No

Treatment History *(for reimbursement purposes, select all that apply)*

IR=Inadequate Response; CI=Contraindication; F=Failure		Dates/Comments:
☐ **Non-biologic systemic therapies** (e.g. csDMARDs, Acitretin)	☐ IR ☐ CI ☐ F	
☐ **Biologic(s)** *(specify)*	☐ IR ☐ CI ☐ F	
☐ **NSAIDs** *(specify)*	☐ IR ☐ CI ☐ F	
☐ **Other(s)**	☐ IR ☐ CI ☐ F	

Assessment Details *(complete as necessary for reimbursement purposes)*

E.g. HAQ, BASDAI, Swollen/Tender Joint Count, PASI, BSA, etc.

Additional Comments/Instructions

Medical Directive

Is the patient medically cleared to start therapy? ☐ Yes ☐ No *(specify)*: _____

Does the patient require QFT Testing? ☐ Yes ☐ No

Physician Acknowledgement

I am the prescribing physician of this patient and this constitutes an original prescription for certolizumab pegol (CIMZIA). I have read and agree to the physician consent on the reverse side of this form. I agree to allow UCB to provide this prescription to the patient's pharmacy of choice.

☐ **If patient's written consent was not provided in Patient Information section**, I confirm receiving verbal consent from the patient to enrol in the Program.

Signature of Physician: _____ Date of Signature (YYYY/MM/DD): ____/____/____

RESET FORM

Patient Consent and Privacy

The Program
The UCBCares™ Program ("UCBCares™" or "Program") is a program that is funded by UCB Canada Inc., 2201 Bristol Circle, Suite 602, Oakville, Ontario, L6H 0J8. The Program is administered by a third-party service provider ("Program Administrator").

Any reference to UCB in this form includes UCB Canada Inc. and its affiliates and their respective employees, consultants, agents and representatives, including, without limitation, Program Administrator and other third-party service providers.

What Personal Information will be collected and processed?
By signing this form and enrolling in the Program, I agree that the Program Administration will, in accordance with the provisions contained herein, collect and process the following:

- My personal information (Personal Information), including, without limitation, my name, date of birth, address, phone number and email address; and
- My personal health information (Personal Health Information), including, without limitation, information relating to my medical condition and treatment

Such Personal (Health) Information will be shared with and accessed by my prescribing physician(s), pharmacist(s), private insurance company(ies), public payer(s) and any other health care provider or payer that may possess the requisite information, including UCB for the purpose of my participation in the Program and for the purposes set out in this form.

How will my Personal (Health) Information be used?
My Personal (Health) Information will be processed by the Program Administrator to:

- Verify my insurance coverage and/or otherwise to arrange for reimbursement;
- Coordinate delivery of medication to me;
- Arrange for injection training;
- Provide me with educational and support services associated with my therapy, including reminders and sharps disposal program;

UCB will receive aggregated and pseudonymized information to conduct market analyses or other commercial analyses, and administer all aspects of the Program, as the Program may change from time to time. I understand that in case of an adverse event, UCB Canada Inc. will receive access to My Personal (Health) Information as UCB may be required to report such serious adverse drug events to Health Canada.

I understand that my Personal (Health) Information may be collected, used and/or stored outside of my province or territory or country.

I agree to be contacted in the future for information regarding my condition, my treatment or any other information required for the administration of the Program by UCBCares™.

I consent to UCBCares™ leaving messages for me, either by email, text message or by voicemail at the addresses and number(s) provided.

I understand that UCB Canada Inc. reserves the right to replace the Program Administrator and I consent to my information being transferred to any future service provider administering the Program.

I understand that UCB Canada Inc. does not, in the normal course, access my Personal Information and my Personal Health Information and relies on the Program Administrator to do so when administering the Program; however, UCB Canada Inc. may directly access Personal Information and Personal Health Information in limited circumstances, for example, to transfer Personal Information and Personal Health Information to a new Program Administrator, to perform audits of the Program in order to evaluate or improve the Program, or for regulatory reporting purposes (e.g. reporting adverse reactions to a government agency).

I understand that UCBCares™ will only disclose Personal Information and Personal Health Information as needed in connection with the provision of the Program or required by law. For example:

- UCBCares™ may disclose my Personal Information and/or Personal Health Information to my health care provider, my pharmacist and third-party service providers for the purpose of administering the Program, administering therapy or providing training in relation to therapy and to insurers for the purpose of reimbursement assistance; or
- UCBCares™ may have to contact my health care provider in the case of an adverse drug event, including a serious adverse drug event, and UCB may be required to report such serious adverse drug events to Health Canada.

Treatment of My Personal and My Personal Health Information
I understand that the Program Administrator will collect, have access to, use, store and disclose my Personal (Health) Information as described herein and all the information collected and recorded in the Program will be treated and maintained as strictly confidential in compliance with applicable data protection laws.

For information about UCB Canada Inc.'s privacy policy, please visit the website https://www.ucb-canada.ca/en/privacy-policy.

What rights do I have regarding My Personal (Health) Information?
Except where the law prohibits me from doing so, I understand that I may obtain a copy of my Personal (Health) Information and can correct any errors by contacting UCBCares™ at the address set out above. Also, I understand that I can withdraw my consent at any time by writing to UCB Canada Inc., 2201 Bristol Circle, Suite 602, Oakville, Ontario, L6H 0J8. However, I understand that withdrawing my consent will result in the termination of my enrolment in the Program. I also understand that any withdrawal of my consent will not be retroactive and any activities relating to Personal (Health) Information processed prior to my withdrawal will not be affected.

Financial Assistance
I understand that any financial assistance provided to me may be reportable income to public or private payers or government agencies. I understand that I am solely responsible for such reporting as well as for ensuring compliance with accepting any such financial assistance.

Changing the Program
I understand that UCB may change, modify, or discontinue the Program at any time without notice to me.

Physician Consent and Disclosure

As the prescribing physician of this patient, I acknowledge and consent UCB to contact me and use my prescribing information for the purpose of administering and monitoring the Program and, without limitation, with regard to reimbursement, injection training and patient care.

Also, I consent to UCB processing any of my information and any information that I provide with respect to the patient that is necessary to assist the patient in obtaining any services or assistance the patient has authorized and consented to and I agree to allow UCB to provide this script to the pharmacy chosen by the above-named patient. This script represents the original prescription drug order.

 CA-CZ-2400002