Pr Adtralza® (tralokinumab)

Enrolment Form

For patients with private insurance

Fax completed form to 1-833-760-6923 or email to info@myadvantagesupport.ca
For inquiries, call: 1-833-729-6923

myADvantage™ Support Program

1. PATIENT INFORMATION

First name	☐ Male ☐ Female ☐ Other
Last name	Date of birth (YYYY-MM-DD)
Address	
City/Province /Postal code	
Phone number	Consent to voice mail: ☐ Y ☐ N
Email	Consent to email: ☐ Y ☐ N
Best time to contact: ☐ AM ☐ PM ☐ Other _____	
Language preference: ☐ English ☐ French ☐ Other _____	
Alternative contact name	
Alternative contact phone number	

2. PATIENT CONSENT

I wish to participate in the MyADvantage™ Support Program as described by my treating physician and I have read and fully understand the Patient Consent and Privacy Information on the reverse of this form and agree to the collection, use, and disclosure of my personal information in accordance with those terms.

☐ I authorize the collection and use of my personal information, any observations, and findings found during the course of this program by the Program Administrator and its communication in a de-identified and aggregated form to LEO Pharma for educational purposes, for the purposes of program assessment, improvement and financial administration, for regulatory purposes, for product or program development or in order to comply with applicable laws. I recognize that I will not be compensated for participation in this program. I know that I may withdraw consent for my information to be included in the aggregated data at any time by emailing info@myadvantagesupport.ca.

☐ Patient Signature _____

Date (DD/MM/YY) _____

OR

☐ Verbal consent obtained by the patient on (DD/MM/YY) _____

Patient or legal representative if patient is under 18 years old.

3. MEDICAL INFORMATION

*Diagnosis: ☐ Moderate-to-severe atopic dermatitis

Test Scores:	BSA	EASI
	IGA	DLQI

Special site involvement: ☐ Yes ☐ No

Affected areas _____

Patient has trialed two or more medium-to-high potency topical corticosteroids:	☐ Yes ☐ No
Patient has trialed topical calcineurin inhibitor(s):	☐ Yes ☐ No
Patient has trialed phototherapy:	☐ Yes, _____ weeks ☐ No ☐ No access
Is the patient medically cleared to start treatment?	☐ Yes ☐ No

If **No**, please provide instructions

4. PRESCRIBER INFORMATION AND CONSENT

Prescriber name	License #
Practice Address	
City/Province/Postal code	

Preferred contact method: ☐ Phone ☐ Fax ☐ Email

Contact details _____

This form constitutes a legal prescription for the above-mentioned patient. I authorize representatives of the MyADvantage™ Support Program ("the Program") to forward the prescription on my behalf to the pharmacy chosen by the patient. I have read and fully understand the Prescriber Consent and Privacy Information on the reverse of this form and agree to the collection, use, and disclosure of my personal information in accordance with those terms.

Prescriber Signature _____

Date (DD/MM/YY) _____

Notes

5. PRESCRIPTION INFORMATION

Type of Device	☐ Pre-filled **PEN** (DIN 02540193) **PrADTRALZA®** Tralokinumab injection 300 mg/2 mL Solution for subcutaneous injection	☐ Pre-filled **SYRINGE** (DIN 02521288) **PrADTRALZA®** Tralokinumab injection 150 mg/1 mL Solution for subcutaneous injection
New Enrolment/Initial	☐ 600 mg loading dose, followed by 300 mg every 2 weeks	
Maintenance	☐ 300 mg every 2 weeks ☐ 300 mg every 4 weeks	
Duration of refills	☐ 6 months ☐ 12 months ☐ Other _____	

6. RAPID ACCESS PROGRAM

The Rapid Access Program is an optional program that initiates patients on treatment while reimbursement options are being navigated. If the option below is not selected, the program will prioritize securing reimbursement before initiating therapy.

☐ I want my patient to start on bridging through the Rapid Access Program

By clicking on the above checkbox, I acknowledge that LEO Pharma retains the right to modify or discontinue the Rapid Access Program at any time, including in instances where reimbursement in not secured.

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Patient Consent

The words "you" and "your" on this page refer to the patient. "The Program" refers to the MyADvantage™ Support Program, currently administered by NavieGo Patient Programs LTD (the "Program Administrator").

The Program is sponsored by LEO Pharma Inc. ("LEO Pharma") and overseen and administered by the Program Administrator. You understand that the Program is intended to assist in navigation of reimbursement options and facilitating ongoing reimbursement, provide financial support if applicable, and provide additional treatment-related services, such as injections and injection training, educational services, and adherence monitoring and treatment efficacy (collectively, the "Services").

You understand that any financial assistance provided to you as a result of your enrolment in the Program may be reportable income to public or private payers or government agencies. You understand that you are solely responsible for such reporting as well as for ensuring compliance with accepting any such financial assistance.

You understand that it is your right to refuse to sign this consent form, and that if you do not provide consent, you will not be provided with access to the Program. Participation in the Program is not required for you to receive your medication.

You confirm that the information contained in this form is complete and accurate to the best of your knowledge. You acknowledge that LEO Pharma reserves the right to modify or terminate the Program at any time, including that it may change Program Administrators in which case your personal information that has been collected will be shared with the new Program Administrator.

By signing this form, you agree to enrol in the Program and authorize your personal information to be collected, used, and disclosed as described below. You consent to be contacted by representatives of the Program to receive the Program Services. You authorize your healthcare providers and their staff to disclose your personal information to the Program Administrator.

Drug Safety

LEO Pharma has a legal obligation to collect, monitor, and maintain records of product quality complaints, adverse events, and other safety experiences. If you experience an adverse event, or other safety experience, LEO Pharma and its representatives will retain your information for these purposes. Pseudonymized personal data pertaining to safety cases is only shared with Health Authorities when required, and the personal identifiers are limited in every case handling step. LEO Pharma may contact you or your healthcare provider to request further information about your adverse event or other safety experience.

Physician Consent

I consent to the use of my prescribing information by the Program Administrator and LEO Pharma for the purpose of administering and monitoring the Program.

I consent to be contacted by representatives of the Program Administrator and LEO Pharma Inc. about the patient, the product, the Program, and/or for any adverse events or other safety experiences reported by the patient.

I give permission for LEO Pharma to view the MyADvantage™ de-identified and aggregated patient enrolment status for, but not limited to, sales and marketing purposes.

I understand that LEO Pharma reserves the right to modify or terminate the Program at any time, including that it may change Program Administrators in which case my personal information that has been collected will be shared with the new Program Administrator.

Personal Information: Collection, Use, and Disclosure

For Patient Only

To participate in the Program, you may be asked to provide personal information to representatives of the Program including:

- Personal information (e.g., contact information or proof of Canadian citizenship/residency);
- Financial information;
- Information related to insurance coverage (e.g., information necessary to maintain insurance coverage); and
- Personal health information and medical condition (e.g., patient outcome questionnaires) (collectively, the "Personal Information").

This Personal Information will be collected, used, disclosed, and stored by the Program Administrator to provide the Services and to receive feedback about your experience with the Program and the Program Services for the purposes of improving the Program. This information may be shared with:

- LEO Pharma, or its affiliates and third-party service providers;
- Your public and private insurers; and
- Your healthcare provider(s), who may share your information with your insurers.

You authorize the Program Administrator to obtain further information from your prescribing physician and health insurance company as deemed necessary to ensure the accuracy and completeness of your Information and to administer the Program, and that such further information may include personal information and/or personal health information.

For Patient and Physician

All personal information collected as part of the Program will be:

- Maintained in accordance with applicable legislation, regulations, and guidelines and in accordance with LEO Pharma's Privacy Statement. A copy of the Privacy Statement is available at www.leo-pharma.ca/Privacy-Statement;
- Protected by adequate physical, administrative, and technical safeguards against loss or theft, and against unauthorized consultation, communication, copying, use, or alteration. These safeguards will apply regardless of the format in which your information is stored; and
- Kept in a personally identifiable format only if needed for the purposes described below under Drug Safety.

LEO Pharma may use your de-identified and aggregated information for various purposes such as evidence generation, including monitoring, assessing, and improving the Program. Your information may be transferred, stored, and/or processed outside of your home province/territory and/or outside of Canada and the privacy laws of those jurisdictions may be less stringent than the laws of Canada and/or your home province/territory.

You can access or correct your personal information held by the Program Administrator at any time by contacting the Program at 1-833-729-6923.

If you have any questions regarding this consent form or other questions relating to the Program or Program Services, please call 1-833-729-6923.

Withdrawing Consent (applies to Patient and Physician)

You can revoke your consent to the above and withdraw from the Program at any time by calling 1-833-729-6923 or by email at info@myadvantagesupport.ca. You acknowledge that your withdrawal is not retroactive and, as such, any activities related to your personal information prior to your withdrawal to the Program will not be affected. Your personal information will be deleted and/or securely maintained in accordance with applicable legislation, regulations, guidelines, and LEO Pharma's Privacy Statement.

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