UNIK ACCESS PROGRAM

Phone: 1 855 756-7660 • Fax: 1 855 756-7661
Email: UnikAccessProgram@innomar-strategies.com

Pr Lysodren®
(mitotane)

PATIENT ENROLMENT FORM

ENROLMENT OPTIONS:

Full service ☐ Yes ☐ No

If **No,** please indicate desired services:

Support for reimbursement/navigation ☐ Yes ☐ No
Follow-up calls ☐ Yes ☐ No
Compliance calls ☐ Yes ☐ No

DIAGNOSIS : Inoperable adrenal cortical carcinoma ☐ Functional ☐ Non-Functional

_____

PATIENT INFORMATION: To be completed by the patient or his/her legal guardian.

_____ _____ DATE OF BIRTH: ____/____/____ GENDER: ☐M ☐F
FIRST NAME LAST NAME MM DD YY

_____
ADDRESS

_____ _____ _____
CITY PROVINCE POSTAL CODE

_____ _____
PREFERRED PHONE NUMBER ALTERNATE PHONE NUMBER LEAVE MESSAGES: ☐Yes ☐No

_____ _____ PREFERRED TIME OF CALL: ☐AM ☐PM ☐EVENING
PREFERRED EMAIL ALTERNATE EMAIL

PHYSICIAN INFORMATION:

_____ _____
NAME SPECIALTY

_____
ADDRESS

_____ _____ _____ _____ _____ _____
CITY PROVINCE POSTAL CODE PHONE NUMBER FAX NUMBER EMAIL

PREFERRED METHOD OF CONTACT ☐ PHONE ☐ FAX ☐ EMAIL

PRESCRIPTION (starting daily dose):

Lysodren® _____ ☐ g ☐ mg ☐ t.i.d ☐ q.i.d Refill _____ times

_____ _____ _____
PHYSICIAN SIGNATURE LICENSE NUMBER DATE

PHYSICIAN AUTHORIZATION:

I am prescribing as per my clinical judgement and certify that the use of Lysodren® for this patient is based on my clinical decision-making. I have reviewed the Lysodren® *product monograph and informed the patient (or their parent or legal guardian) about the potential benefits and risks associated with its use. I consent to be contacted by representatives of Innomar or Medunik regarding the patient, Lysodren®, the Program or any product quality complaint or adverse event experienced by the patient. I consent to the use of my prescribing information for administration or monitoring purposes, as well as assessing or demonstrating the effectiveness of the Program. I understand that health economics and outcome-based studies may be conducted in the future and I consent to being contacted by representatives of Innomar or Medunik for related information.*

_____ _____
PHYSICIAN SIGNATURE DATE

Please see reverse for Patient Consent and Privacy →

PATIENT CONSENT AND PRIVACY

AGREEMENT TO DISCLOSE HEALTH INFORMATION

Medunik Canada has contracted with Innomar (the "Administrator") to provide the Unik Access Program (the "Program"). As part of my enrolment in the Program, I accept and consent to the following:

- My Health Care Providers, the Administrator and the Unik Access Program personnel ("Program Personnel") may collect, use and disclose my Health Information amongst themselves and store my Health Information for the purposes of providing program-related services selected above in the enrolment options.
- Program Personnel may contact me by my preferred means of contact, including electronic communication, regarding information required to administer the program tailored to the program-related services selected above in the enrolment options.

I further understand that:

• The Administrator will collect, use and store my Health Information at all times in accordance with applicable laws, including the Personal Information Protection and Electronic Documents Act and any substantially similar applicable provincial legislation governing the protection of personal information.

• Program Personnel will not (i) collect, use, disclose or store my Health Information for any purpose other than the activities outlined above (Support for reimbursement/navigation, follow-up calls and compliance calls), or (ii) disclose my Health Information to anyone other than my Healthcare Providers (including Medunik Canada and its employees), unless the Health Information that identifies me is removed (for example, my name and address).

• Notwithstanding the foregoing, Medunik Canada may, either directly or indirectly through a third party auditor, access Health Information collected by the Administrator for quality control purposes or to ensure Administrator's compliance with applicable laws.

• At any time, by mailing or faxing a signed request to the Administrator at the fax number provided above or to the Administrator at the address below:

- I may change my enrolment options selection
- I may withdraw my consent, but if I do so, I understand that to the extent that such consent is necessary to provide the services under the Program, my participation in the Program may be terminated and, among other things, I may not be able to obtain assistance with reimbursement for Lysodren®.

• Except where prohibited by law, I may obtain a copy of my Health Information and may correct any errors and/or direct any questions regarding the collection, use, disclosure and storage of my Health Information to the Administrator at the address below. Moreover, the withdrawal of my consent will not have a retroactive effect with respect to information about me already collected and disclosed.

• Telephone calls to or from the Administrator in the course of its administration of the Unik Access Program may be monitored or recorded for my protection and that of the Administrator.

• My Health Information may be collected, used, disclosed and/or stored outside of my province or territory or country and the laws of the location where they are stored regarding privacy may be less stringent than the laws of Canada and its provinces.

• I am entitled to a copy of this document.

Administrator is Innomar Strategies Inc., located at 2600 Alfred-Nobel, Ville Saint-Laurent, QC H4S 0A9 and its affiliates.

Health Information includes, without limitation, my personal information (name, address, phone number, date of birth, financial information, etc.) and personal health information (medical history, medical condition(s), information related to my treatment, information related to my health insurance, etc.).

HealthCare Providers include, without limitation, my physicians, nurses, pharmacists and health insurer(s).

Unik Access Program is the Unik Access Program provided by Medunik Canada for the purpose of assisting patients in obtaining access to Lysodren®.

Unik Access Program Personnel include the employees and consultants of the Administrator.

I, the undersigned, hereby confirm that:

a) I have read, understand and accept with the terms and conditions of this Unik Access Program consent form. I understand, agree with and consent the services offered by the Unik Access Program.

b) I have been given the opportunity to discuss the Unik Access Program with my HealthCare Provider. I understand that my participation in the Program is voluntary and if I choose not to participate, this will not impact my medical treatment or insurance coverage eligibility. However, if I do not sign this form, I will not be able to participate in the Unik Access Program and receive assistance from the Administrator, as described above.

c) I understand that the Unik Access Program is not intended to provide medical advice or medical diagnoses. I agree to always seek the advice of my physician or other qualified healthcare provider if I have health concerns, and not to disregard professional medical advice based on information read or conveyed as part of the Unik Access Program.

_____ _____

PATIENT/ LEGAL GUARDIAN (PRINT NAME) PATIENT/ LEGAL GUARDIAN (SIGNATURE)

_____

DATE (MM/DD/YY)

Médunik Canada
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