



The CELLTRION CONNECT™ Patient Support Program (the "Program") is sponsored and offered by Celltrion Healthcare Canada Limited ("Celltrion") in conjunction with its third-party providers ("Program Administrators"), to support patients who have been prescribed Remdantry™ ("Support Services"). Information contained in this document is used by the Program to facilitate access to Remdantry™.

**PATIENT INFORMATION**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Female ☐ Male ☐ Non-binary ☐  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
Cellphone: \_\_\_\_\_ Okay to leave message: Yes ☐ No ☐ Best time to be contacted: AM ☐ PM ☐  
Tel. (home): \_\_\_\_\_ Known allergies: Yes ☐ No ☐ If yes, please specify: \_\_\_\_\_  
Preferred language: English ☐ French ☐ Other ☐ Please specify: \_\_\_\_\_ Personal health number (PHN): \_\_\_\_\_

**FOR MINOR PATIENT**

Legal guardian name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**PHYSICIAN INFORMATION**

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_  
License number: \_\_\_\_\_  
Office contact name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Tel (office): \_\_\_\_\_ Fax (office): \_\_\_\_\_  
Email: \_\_\_\_\_

**PHARMACY**

Do you have a preferred pharmacy that you are working with? Yes ☐ No ☐

Pharmacy name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Tel: \_\_\_\_\_  
Fax: \_\_\_\_\_

**PHYSICIAN PRESCRIBING SECTION FOR REMDANTRY™**

Refer to page 2 for the recommended dosing. Please ☒ and complete the required information.

☐ Patient is already on infliximab ☐ Patient is new to infliximab  
Patient weight (kg): \_\_\_\_\_ Date of weight: \_\_\_\_\_ Dose: \_\_\_\_\_ mg Provincial formulary code (if applicable): \_\_\_\_\_

**DIAGNOSIS:**

**ADULT**

☐ Rheumatoid Arthritis (RA) ☐ Ankylosing Spondylitis (AS) ☐ Psoriatic Arthritis (PsA) ☐ Plaque Psoriasis (PsO)  
☐ Ulcerative Colitis (UC) ☐ Crohn's Disease (CD) ☐ Fistulising Crohn's Disease (FCD)

**PEDIATRIC**

☐ Ulcerative Colitis (UC) (≥6 years of age) ☐ Crohn's Disease (CD) (≥9 years of age)

**FREQUENCY/DURATION**

Requested start date:\*

☐ Induction: Weeks ☐ 0 ☐ 2 ☐ 6 ☐ Maintenance: Every \_\_\_\_\_ weeks for \_\_\_\_\_ months. Repeat: x \_\_\_\_\_

☐ Administer Remdantry™ dose by IV infusion using infusion clinic standard Remdantry™ protocol.

☐ 1-hour infusion: If my rheumatoid arthritis, Crohn's disease (pediatric or adult), or ulcerative colitis (pediatric or adult) patient has received and tolerated the last three 2-hour infusions, initiate the following order: utilize the current shortened infusion recommended standard protocol to infuse Remdantry™ over no less than 1 hour, or as tolerated, and manage infusion reactions as applicable.

\*The infusion solution must be administered over a period of not less than 2 hours unless a 1-hour infusion is prescribed considering the conditions listed above. Emergency equipment, such as adrenaline, antihistamines, corticosteroids and an artificial airway must be available.

**PRE-MEDICATION ORDER**

☐ No pre-meds required (Do not select any pre-medications below) ☐ Yes, pre-meds are required: Select the desired pre-treatment medication(s) to be administered prior to infusion at the clinic (indicate dose/route):

**PRE-MEDICATIONS**

☐ Diphenhydramine (e.g., Benadryl†) \_\_\_\_\_ mg  
☐ Acetaminophen \_\_\_\_\_ mg  
☐ Hydrocortisone \_\_\_\_\_ mg  
☐ Dimenhydrinate (e.g., Gravol†) \_\_\_\_\_ mg  
☐ Methylprednisolone \_\_\_\_\_ mg

**ADMINISTRATION**

☐ PO **OR** ☐ IV 15-30 min prior to infusion (max 50 mg)  
☐ PO 15-30 min prior to infusion  
☐ IV 15-30 min prior to infusion  
☐ PO **OR** IV 15-30 min prior to infusion  
☐ 15-30 min prior to infusion

Other (indicate):† \_\_\_\_\_

†Please provide patient with a prescription, patient will need to bring other medication to infusion visit.

**TUBERCULOSIS TEST**

☐ Not required  
☐ Positive (+) Date: \_\_\_\_\_  
☐ Negative (-) Date: \_\_\_\_\_

**CHEST X-RAY**

☐ Not required  
☐ Completed results Date: \_\_\_\_\_

**Relevant medical history/Notes:**



**My signature acknowledges that:**

- The above prescription parameters comply with the indications set forth in the Product Monograph.
- I consent to the patient being enrolled in the CELLTRION CONNECT™ Patient Support Program (the "Program").
- I have the patient's consent to share the patient's information in this form with the Program and as needed, to provide the Program's services.
- I consent to Celltrion contacting me with respect to the enrolment of this patient as may be required to administer or deliver the Program or the Support Services, or in the event of an adverse drug event relating to Remdantry™. This prescription is the original prescription that will be sent to the pharmacy chosen by the patient.
- I consent to the Program Administrator or designated agent to forward the prescription to the Program and to the pharmacy as required.
- I consent to the Program Administrator collecting, using and disclosing my information for the purpose of delivering the Support Services, or for contacting me to improve the quality of the Support Services offered under the Program.

Physician name \_\_\_\_\_

Physician signature \_\_\_\_\_

Date† \_\_\_\_\_

†Effective date.  
IV: Intravenous; PO: Per Os.

## RECOMMENDED DOSE\*

### Rheumatoid Arthritis

3 mg/kg IV followed by additional 3 mg/kg doses at weeks 2 and 6 after the first infusion, then every 8 weeks thereafter. Give in combination with methotrexate.

### Ankylosing Spondylitis

5 mg/kg IV followed by additional 5 mg/kg doses at weeks 2 and 6 after the first infusion, then every 6 to 8 weeks thereafter.

### Ulcerative Colitis (Adults and Pediatrics ≥6 years of age)

5 mg/kg IV induction at weeks 0, 2 and 6, followed by 5 mg/kg every 8 weeks thereafter.

### Crohn's Disease (Adults and Pediatrics ≥9 years of age)

5 mg/kg IV induction at weeks 0, 2 and 6, followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter.

### Fistulising Crohn's Disease

5 mg/kg IV induction regimen at weeks 0, 2 and 6, followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter.

### Psoriatic Arthritis

5 mg/kg IV followed by additional similar doses at weeks 2 and 6 after the first infusion then every weeks thereafter. Use with or without methotrexate.

### Plaque Psoriasis

5 mg/kg IV followed by additional 5 mg/kg doses at weeks 2 and 6 after the first infusion, then every 8 weeks thereafter.

\*See Product Monograph for recommended dose adjustments.

## NOTES

## PATIENT CONSENT

The CELLTRION CONNECT™ Patient Support Program (the "**Program**") is designed to support patients in Canada who have been prescribed a Celltrion product. Celltrion administers this Program via third-party service providers appointed by Celltrion ("**Program Administrators**"), and offers various support services for individuals. Depending on eligibility, these services may include education and training, product information, insurance reimbursement assistance, treatment services, or financial assistance (collectively called "**Support Services**").

Any information collected and shared to administer the Support Services may include personally identifiable information ("**Personal Information**") about me. This includes my contact information, date of birth, sensitive health information (such as medical conditions, treatments, care management, health insurance, and prescription details), and any other information disclosed in connection with the Support Services.

I understand and agree that the Program does not provide medical advice or replace the need for me to speak with my treating healthcare provider for medical-related inquiries. I also recognize that my participation in the Program is voluntary.

I understand that Program Administrator employees and/or agents will handle my Personal Information to provide Support Services. This information will be processed in accordance with privacy laws and Celltrion's privacy/data protection standards (available at <https://www.celltrionhealthcare.ca/contactus/law/>).

I agree to Celltrion and the Program Administrators collecting information from and sharing information with my healthcare providers and their staff, pharmacies, pharmacists, insurance companies, provincial public payers, or other healthcare and service providers (collectively referred to as "**Providers**") as necessary to provide me with the Support Services. Celltrion will not use or share my Personal Information for any purpose other than for the Program, unless required or permitted by law.

The Program Administrators may anonymize and aggregate my Personal Information with that of other patients and provide it to Celltrion and its service providers for the purposes of reporting, assessing, auditing, monitoring, improving, or evaluating the Program for the benefit of patients. My anonymized statistical and aggregated information may also be collected, shared, and published with healthcare providers and third parties for reimbursement, publication, or commercial purposes.

I agree to be contacted by the Program Administrators through various means (e.g., phone, fax, email, mail, SMS/text message, etc.) to coordinate Program services or inquire about my experience with the Program to improve the Support Services.

I agree that my de-identified Personal Information may be shared with Celltrion and my Providers for the purpose of reporting adverse events (side effects). Such information may be provided to Health Canada or to another regulatory agency to report any adverse drug events or as otherwise required by law.

I understand that my Personal Information may be stored or processed outside of Canada. If this is the case, then my information would be subject to the laws of the country where it is stored. That country may have laws that require my Personal Information be disclosed to the government under different circumstances than would Canada.

I understand and agree that Celltrion has the right without notice to (1) make changes to the scope of Support Services offered; (2) make changes to the eligibility requirements for the Support Services; or (3) discontinue the Program or any of the Support Services. If at any time Celltrion appoints a new Program Administrator, I will be notified of same and I hereby authorize Celltrion to transfer my Personal Information to the new Program Administrator for the purposes of continuing my participation in the Program. I understand that I have the right to have access to or to correct my Personal Information held by Program Administrators by contacting the Program at [support@celltrionconnect.ca](mailto:support@celltrionconnect.ca), or by telephone at: 1-855-966-1648. I understand that I have the right at any time to withdraw my consent to the use of my Personal Information but if I do decide to do so, I will no longer be participating in the Program or have access to the services.

In signing this form, I consent to the above.

☐ In addition to the above consent, I agree to the Program Administrator contacting me by electronic or other means for the purposes of market research.

I acknowledge that I may at any time opt-out from such communications by advising Program Administrator by email at: [support@celltrionconnect.ca](mailto:support@celltrionconnect.ca).

Patient name (please print) \_\_\_\_\_ Patient signature \_\_\_\_\_ Date \_\_\_\_\_

For more information, please refer to the Remdantry™ Product Monograph.

The Product Monograph is available upon request or it can be accessed at <https://health-products.canada.ca/dpd-bdpp/search>.



1-855-966-1648



1-855-966-2223



[support@celltrionconnect.ca](mailto:support@celltrionconnect.ca)



[www.celltrionconnect.ca](http://www.celltrionconnect.ca)



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