CELLTRION CONNECT™
PATIENT SUPPORT PROGRAM

SEND COMPLETED ENROLMENT FORM TO:

1-855-966-2223 support@celltrionconnect.ca

Questions? 1-855-966-1648

Pr SteQeyma® ustekinumab

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 Steqeyma® (ustekinumab) ("Support Services"). Information contained in this document is used by the Program to facilitate access to Steqeyma®.

PATIENT INFORMATION

Name: _____ Date of birth: _____ Female ☐ Male ☐ Non-binary ☐

Address: _____ Email: _____

Tel. (home): _____ Okay to leave message: Yes ☐ No ☐ Known allergies: Yes ☐ No ☐

Tel. (other): _____ Best time to be contacted: AM ☐ PM ☐ If yes, please specify: _____

Preferred language: English ☐ French ☐ Other ☐ Please specify: _____ Personal health number (PHN): _____

ADDITIONAL LAB TESTS/SERVICES

PLEASE ☑ ALL THAT APPLY

Tuberculosis (TB) test

☐ Completed ☐ Not required ☐ To be completed by the Program

Chest x-ray required

☐ Yes ☐ No

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 STEQEYMA®

☐ Patient is already on Stelara®

☐ Patient is new to ustekinumab

Requested start date: _____

☐ Patient is transitioning to Steqeyma® from another ustekinumab biosimilar (specify): _____

DIAGNOSIS AND DOSAGE

Please ☑ and complete the required information.

Patient weight (kg): _____

Diagnosis

☐ **Adult Plaque Psoriasis**

☐ **Adult Psoriatic Arthritis**

Dose

☐ 45 mg at week 0, 4, and every 12 weeks thereafter

☐ 90 mg at week 0, 4, and every 12 weeks thereafter (if body weight >100 kg)

☐ Other _____

Format

Subcutaneous

☐ Pre-filled syringe

☐ **Adult Crohn's Disease**

☐ **Adult Ulcerative Colitis**

Induction:

Recommended: Single IV tiered dose of Steqeyma® IV based on body weight:

☐ 260 mg (≤55 kg)

☐ 390 mg (>55 kg to ≤85 kg)

☐ 520 mg (>85 kg)

☐ Premedication(s): _____

Intravenous

☐ 130 mg vials

Maintenance:

☐ 90 mg every 8 weeks*

The first subcutaneous dose should be given at week 8 following the IV induction dose.

☐ Other _____

*In some patients (e.g., low inflammatory burden) subsequent doses may be given every 12 weeks thereafter (adjust to every 8 weeks if there is an inadequate response).

Subcutaneous

☐ Pre-filled syringe

Duration: _____

Quantity and refills authorized: _____

Other instructions: _____

Provincial formulary code (if applicable): _____

℞

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 Steqeyma®. 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. Order(s) expire one year from the date of signature.
Prescriber certification: I certify that this prescription is an original prescription and this pharmacy is the only receiver. The original will not be reused.

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, 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.

Patient name (please print) _____ Patient signature _____ Date _____

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