CELLTRION CONNECT™
PATIENT SUPPORT PROGRAM

SEND COMPLETED ENROLMENT FORM TO

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

Question? 1-855-966-1648

Pr Yuflyma® adalimumab

The Celltrion CONNECT™ Patient Support Program (the "Program") is sponsored and offered by Celltrion Healthcare Canada Limited ("Celltrion") through its third-party provider McKesson Canada Corporation ("Program Administrator"), to support patients who have been prescribed Yuflyma® (adalimumab) ("Support Services"). Information contained in this document is used by the Program to facilitate access to Yuflyma®.

PATIENT INFORMATION

Name: _____ Date of birth: YYYY-MM-DD

Address: _____ Email: _____

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

Tel. (other): _____ Best time to be contacted: AM ☐ PM ☐

☐ **By checking this box, I accept that the Program Administrator may communicate with me via phone and/or electronic means, to provide me with information relating to the Program, including free nutritional counselling. I acknowledge that I may at any time opt-out from such communications by advising the Program Administrator by email at support@celltrionconnect.ca.**

Preferred language: English ☐ French ☐ Other ☐ Please specify: _____

VACCINE AND TUBERCULOSIS (TB) ASSESSMENT

TB test ☐ TB Skin Test ☐ QuantiFERON TB Gold Test
☐ Not required ☐ Positive (+) Date: YYYY-MM-DD ☐ Negative (-) Date: YYYY-MM-DD

Chest x-ray ☐ Not required ☐ Completed results Date: YYYY-MM-DD

Shingles vaccine ☐ Required Brand: _____ # of doses: ____ **Pneumococcal vaccine** ☐ Required Brand: _____ # of doses: ____

Relevant medical history/notes: _____

OPTIONAL TESTING SERVICES

Please ☑ all that apply

☐ **Therapeutic Drug Monitoring** ☐ Baseline: _____ ☐ Repeat in ____ months

☐ **Calprotectin Testing:** ☐ IBDoc® OR ☐ QuantOn Cal®
☐ Baseline: _____ ☐ Repeat in _____ months

OPTIONAL COUNSELLING

☐ **Nutrition** ☐ Yes ☐ No

PHYSICIAN INFORMATION

Name: _____

Address: _____

Tel (office): _____ Fax (office): _____

Email: _____

SPECIALTY PHARMACY

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

Name: _____

Address: _____

Tel: _____

PHYSICIAN PRESCRIBING SECTION FOR YUFLYMA®

Please ☑ and complete the required information.

DOSAGE AND ADMINISTRATION

Requested start date: YYYY-MM-DD

Patient prescribed methotrexate? Yes ☐ No ☐

Drug: Yuflyma® (adalimumab)

Auto-injector
☐ 40 mg [DIN: 02523779] ☐ 80 mg [DIN: 02535084]

Pre-filled syringe
☐ 40 mg [DIN: 02523760] ☐ 80 mg [DIN: 02535076]

Pr Yuflyma® adalimumab

DIAGNOSIS AND DOSING FOR SUBCUTANEOUS INJECTION

Please refer to the Product Monograph for complete dosing and administration information.

Adult with:

☐ Moderately to severely active **rheumatoid arthritis**	☐ 40 mg every 2 weeks
☐ **Psoriatic arthritis**	☐ 40 mg every 2 weeks
☐ Active **ankylosing spondylitis**	☐ 40 mg every 2 weeks
☐ Moderately to severely active **Crohn's disease**	☐ **Initial:*** Week 0: 160 mg; Week 2: 80 mg ☐ **Maintenance:** Week 4 onward: 40 mg every 2 weeks
☐ Moderately to severely active **ulcerative colitis**	☐ **Initial:*** Week 0: 160 mg; Week 2: 80 mg ☐ **Maintenance:** Week 4 onward: 40 mg every 2 weeks
☐ Active moderate to severe **hidradenitis suppurativa**	☐ **Initial:*** Week 0: 160 mg; Week 2: 80 mg ☐ **Maintenance:** Week 4 onward: 40 mg every week
☐ Chronic moderate to severe **plaque psoriasis**	☐ **Initial:*** Week 0: 80 mg ☐ **Maintenance:** Week 1 onward: 40 mg every 2 weeks
☐ Non-infectious **uveitis** (intermediate, posterior and panuveitis)	☐ **Initial:*** Week 0: 80 mg ☐ **Maintenance:** Week 1 onward: 40 mg every 2 weeks

Adolescent patient (12 to 17 years of age) with:

☐ Active moderate to severe **hidradenitis suppurativa**	☐ **Initial:*** Week 0: 80 mg ☐ **Maintenance:** Week 1 onward: 40 mg every 2 weeks in patients weighing ≥30 kg

Pediatric patient ≥2 years of age with:

☐ Moderately to severely active **polyarticular juvenile idiopathic arthritis**	☐ 40 mg every 2 weeks in patients weighing ≥30 kg
☐ Chronic non-infectious anterior **uveitis**	☐ 40 mg every 2 weeks in patients weighing ≥30 kg in combination with MTX

☐ **OTHER** ☐ Initial dosing/Frequency:

☐ Maintenance dosing/Frequency:

For ONTARIO ONLY: Enter the LU code of the selected indication _____

Other prescription instructions:

***Dosage format:** ☐ 40 mg ☐ 80 mg

Quantity authorized/Refills:

℞

My signature acknowledges that: 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 Yuflyma®. This prescription is the original prescription that will be sent to the pharmacy chosen by the patient.

I consent to the Program Administrator designated agent for the purposes of forwarding the prescription to the Program and to the pharmacy. 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. **Please see consent details on back.**

CLINIC STAMP

Physician signature

College license #

YYYY-MM-DD

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.

PATIENT CONSENT

The Celltrion Connect Patient Support Program (the "Program") is a patient support program provided by Celltrion to Canadian patients who have been prescribed Yuflyma®. The Program services may include health/disease/product information, insurance reimbursement assistance, treatment services or financial assistance (the "Support Services"). A third-party service provider, McKesson Canada Corporation, is the administrator of the Program ("Program Administrator"). Its employees and/or agents handle your personal information, which is processed in accordance with privacy laws and Celltrion privacy/data protection standards, as may be designated from time to time by Celltrion.

I understand and consent to the following:

(1) that the personnel of the Program Administrator ("Program Personnel") may contact me by any means (e.g., phone, fax, email, mail, etc.) for the purposes of administering the Support Services;

(2) that my personal health information may be collected, used and stored by the Program Administrator and by my healthcare providers involved in the delivery of the Support Services;

(3) that my personal information may be exchanged among Program Personnel, my healthcare providers, and my insurers and/or other payers, Celltrion and/or Celltrion's agents and service providers, such as information technology providers, for purposes consistent with the Program's administration and the Support Services; and

(4) that my healthcare providers and the Program Administrator may share my personal information with Celltrion as necessary for Celltrion to comply with its legal and regulatory obligations, including with respect to safety and adverse drug reporting.

I understand that the Program Administrator may also share de-identified information (i.e., where personal identifiers are removed) and aggregate data (combined with other data) with Celltrion to conduct analyses for commercial, market and scientific research/publication purposes to improve the Program, or as otherwise may be permitted by law.

I understand that the collection, use and disclosure of information contemplated herein may involve the transfer of the information in jurisdictions located outside of Canada (including in the United States), where local laws may require the disclosure of personal information to governmental authorities under circumstances that are different than those that apply in Canada. The reasonable contractual measures taken to protect my personal information while processed or handled by these third parties outside of my country of residence may be subject to foreign legal requirements, for example requirements to disclose personal information to government authorities in those countries.

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 Administrator by contacting McKesson Canada, located at 4705 Dobrin, Saint-Laurent, Quebec, H4R 2P7, and 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.

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 the Program Administrator by email at: support@celltrionconnect.ca.

Patient signature: _____ Date: YYYY-MM-DD _____

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www.celltrionconnect.ca

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