Pr INFLECTRA®
INFLIXIMAB

Hospira
A Pfizer Company

Patient Enrolment, Rx and Consent Form

Please fax to **1-844-295-0219** upon completion.
To speak to a representative, call toll-free to **1-844-466-6627**.

PATIENT INFORMATION [to be completed by patient]
Name:
Address:
Tel. (Home):
Tel. (Other):
Okay to leave messages: ☐ Yes ☐ No
Email:

OFFICE INFORMATION [office use only]
Physician Name:
Address:
Tel. (Office):
Fax (Office):
Office Contact Name:
Email:

PHYSICIAN PRESCRIBING SECTION	**PLEASE ✓ AND COMPLETE THE REQUIRED INFORMATION**
Patient weight:	**Indication:**
Date of weight: dd / mm / yyyy	☐ **PSO** ☐ **RA** ☐ **PsA** ☐ **AS**
Dose: mg (Exact)	☐ **UC** ☐ **CD** ☐ **FCD**
# Vials 100 mg vials	

Frequency / Duration (check all that apply and indicate #weeks between maintenance doses and # of repeat doses)

Induction ☐ weeks ☐ 0 ☐ 2 ☐ 6 **Maintenance** ☐ Every____Weeks for____months. Repeat x ___

Administer INFLECTRA® dose by IV infusion using infusion clinic standard INFLECTRA® protocol

Known Allergies: ☐ No Known Drug Allergies

PRETREATMENT ORDERS

Option 1: ☐ No pre-meds required
Option 2: ☐ Please ✓ requested pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route)

☐	Diphenhydramine (e.g., Benadryl**)	☐ PO	☐ IV
☐	Acetaminophen	PO	
☐	Hydrocortisone 100 mg	IV	
☐	Dimenhydrinate (e.g., Gravol**) 50 mg	☐ PO	☐ IV
☐	Methylprednisolone	IV	
☐	Other (indicate): **		

**please provide patient with a prescription, patient will need to bring other medication to infusion visit

TB TEST			**CXR**	
☐ **Not Required**	☐ **Positive (+)** Date: dd / mm / yyyy	☐ **Negative (-)** Date: dd / mm / yyyy	☐ **Not Required**	☐ **Completed Results** Date: dd / mm / yyyy

Relevant Medical History / Notes

PHYSICIAN SIGNATURE: †Date: dd / mm / yyyy

†Effective date. Order(s) expires 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 SIGNATURE: Date: dd / mm / yyyy

☐ I have read and understood the Patient Consent text printed on the back of this form and agree to the collection, use and disclosure of my Health Information in accordance with these terms.

☐ I consent to the receipt of electronic communications from Hospira Healthcare Corporation, the Administrator, and Program Personnel, for the purposes of determining my eligibility for the Program, conducting Program-related activities and in the delivery of Program services to me. Email communications may be sent to the address I have provided above. I understand that the privacy and security of unencrypted email communications cannot be guaranteed, and that I can withdraw my consent at any time by contacting Hospira Healthcare Corporation, a Pfizer Company at 17300 Trans-Canada Highway, Kirkland, QC, Canada, H9J 2M5 or by calling 1-866-488-6088.

AGREEMENT TO DISCLOSE HEALTH INFORMATION ("Patient Consent")

Hospira Healthcare Corporation, a Pfizer Company has contracted with the Administrator to provide the INFLECTRA Patient Assistance Program (the "Program"). As part of my enrolment in the Program, I agree and consent to the following:

- My Health Care Providers, the Administrator and the INFLECTRA Patient Assistance Program personnel ("Program Personnel") may collect, use, disclose amongst each other and store my Health Information for the purposes of determining my eligibility for the Program, conducting Program related activities (including without limitation any adverse reaction reporting) and delivering Program Services to me (including, but not limited to, reimbursement navigation, infusion scheduling, pharmacy dispensing and financial assistance);
- Program Personnel may contact me and leave messages for me regarding my Health Information or any other information required for the administration of the Program;
- The Administrator and Program Personnel can administer the prescribed INFLECTRA® medication to me during a pre-scheduled specialty clinic appointment. Such treatment shall include administration of prescribed pre-medication and management of infusion related reactions or emergencies during the infusion treatment appointment.

I further understand that:

- Program Personnel will not (i) collect, use, disclose and store my Health Information for any activity other than the activities contemplated above, or (ii) disclose with anyone other than my Healthcare Providers, any of my Health Information, unless the Health Information that identifies me is removed (for example, my name and address); provided, however, that Health Information may be disclosed as required by law for reporting of any adverse reaction;
- I may withdraw my consent at any time by mailing or faxing a signed request to the Administrator at the fax number set out above or to the Administrator at the address below, but if I do so, I understand that to the extent that such consent is necessary to provide the Program services, my participation in the Program may be terminated and, among other things, I may not be able to get help with reimbursement for INFLECTRA®;
- Except where prohibited by law, I may obtain a copy of my Health Information and can 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;
- Any calls to or from the Administrator in the course of its administration of the Program may be monitored or recorded for control of quality and for training purposes;
- Administrator may share Health Information that does not identify me with third parties even after I withdraw my consent;
- My Health Information may be collected, used, disclosed and/or stored outside of my province or territory or country, and that the laws of those countries regarding privacy may be less stringent than the laws of Canada and its provinces;
- The terms and conditions of this agreement and that I am entitled to a copy of this document.

Administrator is Innomar Strategies Inc., #2 - 3450 Superior Court, Oakville, ON, L6L 0C4.

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 relating to my treatment, information relating to my health insurance, etc.).
Health Care Providers includes, without limitation, my doctors, nurses, pharmacists and health insurer(s).
INFLECTRA Patient Assistance Program is the INFLECTRA Patient Assistance Program provided by Hospira Healthcare Corporation for the purpose of assisting patients in obtaining access to INFLECTRA®.
INFLECTRA Patient Assistance Program personnel include the employees and consultants of the Administrator.