TEZSPIRE™ Enrolment Form

FAX: 1-833-736-4442 • EMAIL: connect360@innomar-strategies.com

CONNECT360 Patient Support Program

TEZSPIRE™MC
tezepelumab injection
tézépélumab injectable

Form cannot be processed without physician's and patient's/legal representative's consent.
For any questions, please call 1-833-360-2666, Mon-Fri, 8am-8pm EST.

1. PATIENT INFORMATION

Full name _____ Email _____

Home address _____ Home phone _____ Mobile phone _____

City _____ Province _____ Postal code _____ Permission to leave voicemail? ☐ Yes

Date of birth DD / MM / YY Gender ☐ M ☐ F ☐ Other Best time to be reached ☐ Morning ☐ Afternoon ☐ Evening

LEGAL REPRESENTATIVE/LEGAL GUARDIAN INFORMATION (if applicable)

Full name _____ Relationship to patient _____

Phone number (if different from above) _____

2. PATIENT ELIGIBILITY (To be completed by physician)

Please check one or both boxes as appropriate. For example, if your patient is switching to TEZSPIRE™ and fulfills the criteria associated with both boxes, please select both boxes.

☐ **I hereby confirm the patient:**

a. Is ≥12 years of age and is being prescribed TEZSPIRE™ as an add-on maintenance treatment for severe asthma.

b. Has experienced two or more clinically significant asthma exacerbations in the past 12 months.

c. Has received a high dose inhaled corticosteroid (ICS), **plus** at least one* additional maintenance medication (e.g., long-acting beta-agonist (LABA)).

* **Quebec only**: Patient has received an ICS dose equivalent to 1000 mcg fluticasone propionate, a LABA, **and trial of a** LAMA, LTRA or theophylline.

• **Daily dosage of ICS:** _____ **mcg** (fluticasone propionate or equivalent)

If the patient is currently prescribed a biologic for severe asthma

☐ **I hereby confirm the patient:**

a. Met the eligibility criteria in the above section at the time of initiation of their current biologic.

• **Name of current biologic:** _____

If the patient is currently receiving maintenance treatment with oral corticosteroids

Dose _____ mg/day Date of initiation DD / MM / YY

3. PATIENT CONSENT

Required:

☐ I have read and understand the **Patient Consent and Privacy Information** on the reverse and agree to the collection, use and disclosure of my Personal Information and health information in accordance with those terms.

OR

☐ Patient and/or their legal representative or guardian has given verbal consent to proceed with enrolment at this time and the Program Administrator will provide the **Patient Consent and Privacy Information** at a later date.

_____ DD / MM / YY

Patient/legal representative or guardian signature Date

_____ DD / MM / YY

Name of person collecting verbal consent Date

Optional:

Your decision on the following will have **no impact** on your ability to access the products and services through this Program.

Do you (either the patient, or the patient's legal representative/guardian, if applicable) consent to:

☐ **Yes** Be contacted by AstraZeneca's Program Administrator or a third-party working on its behalf for purposes of market research to help improve support programs, patients and clinician information and diagnostic testing initiatives.

☐ **Yes** Be contacted by an AstraZeneca Medical Evidence Lead or a third-party working on its behalf, to understand your interest in participating in a Real-World study.

4. PRESCRIBING PHYSICIAN INFORMATION

Full name _____ Office email _____

Office contact _____ Office phone _____ Office fax _____

Office address _____ Preferred contact method ☐ Email ☐ Phone ☐ Fax

City _____ Province _____ Postal code _____

5. PRESCRIPTION INFORMATION AND PRESCRIBING PHYSICIAN AUTHORIZATION

TEZSPIRE™ (tezepelumab injection) pre-filled pen /
TEZSPIRE™ (tezepelumab injection) pre-filled syringe

Initial Rx: ☐ 210 mg SC Q4W x _____ repeats

I certify that I am the patient's prescribing physician and confirm that the patient has been prescribed TEZSPIRE™ as per the Canadian Monograph. I have prescribed the product based on my independent medical judgement and the patient's informed consent. I agree to be contacted by the Program Administrator, or any future program administrator in respect of the Program. I understand that my personal information will be used for the purposes of the Program. This prescription represents the original prescription drug order. I agree to keep all confidential information provided to me about the Program in strict confidence.

_____ _____ DD / MM / YY

Physician signature License # Date

6. PATIENT CONSENT AND PRIVACY INFORMATION

The purpose of the Connect360° Program ("Program") is to provide patients with support including reimbursement navigation and/or services related to the Product.

TEZSPIRE™ is part of a global strategic collaboration between Amgen and AstraZeneca. AstraZeneca Canada Inc. ("AstraZeneca") is managing the Program on behalf of both companies. The Program is administered by Innomar Strategies Inc., ("Program Administrator"), an independent third party. AstraZeneca may, at its sole discretion, appoint a new Program Administrator at any time. By signing this informed consent form, you consent to the transfer of your Personal Information, as well as the prescription itself (if applicable), to any future Program Administrator, if required.

You understand that the Program is not intended to provide medical advice or medical diagnoses. You should always seek the advice of your physician if you have any health concerns. You have discussed the benefits and risks of the Product with your physician and have decided to start treatment. You understand that: (i) it is your right to refuse to sign this consent form, (ii) if you do not give such consent, you will not be provided with access to the Program, and (iii) you do not need to participate in the Program to obtain the Product; however, AstraZeneca and the Program Administrator do not provide support for Product not obtained via the Program.

AstraZeneca reserves the right at any time, without notice, to modify, discontinue or terminate the Program.

By signing this form you agree to enrol in the Program and authorize for your information, including contact information and information about your insurance, prescriptions, medical condition, diagnostic test results and other health information from your health care providers ("Personal Information") to be collected, used and disclosed as described in this informed consent form. In addition, you consent to the Program Administrator contacting you to provide the Program services. If you have provided your telephone number, the Program services may include Program-related communications (such as appointment reminders) via text messages. You may stop these communications at any time by replying "stop". Charges from your phone plan provider may apply. Even if you stop text messaging communications, you will still be enrolled in the Program until (i) you withdraw, (ii) are withdrawn because your physician feels it is the right decision or (iii) the Program ends.

Personal Information: Collection, Use and Disclosure

To participate in the Program, you are required to provide your Personal Information to the Program Administrator and you authorize the Program Administrator to contact your insurer and your healthcare providers for additional information.

AstraZeneca will have access to Personal Information for Program auditing and troubleshooting purposes and when required to fulfill its legal adverse drug event reporting and complaints handling obligations to Health Canada.

Information collected during your participation in the Program by the Program Administrator may be provided to AstraZeneca in a coded format which may be used by AstraZeneca for internal evaluation purposes, such as to determine whether certain aspects of the Program require refinement. Coded information means that information that can personally identify you is replaced by a code. Only the Program Administrator has a key to that code.

Your **Identifiable** Personal Information will be confidentially collected, used and disclosed by the Program Administrator to provide the Program services, such as the delivery of the Product to your home and the administration and monitoring of the Program, and may be shared with:

- AstraZeneca for Program auditing and troubleshooting purposes and to fulfill its legal adverse drug event reporting and complaints handling obligations to Health Canada;
- Public and private insurers for the purpose of investigating drug reimbursement options; and
- Healthcare provider(s), who may share your Personal Information with your insurers for the purpose of investigating drug reimbursement options.

Personal Information may also be shared with or accessible by service providers of the Program Administrator or AstraZeneca (including affiliates acting in this capacity). Some of these service providers may be located outside of Canada, including Ireland, Mexico, and India.

Your Personal Information collected as part of the Program will be protected by reasonable physical, administrative and technical safeguards to protect against loss, theft and unauthorized consultation, communication, copying, use or alteration.

Aggregated Data

AstraZeneca may also use **your** coded data to generate fully de-identifiable aggregated data that does not contain Personal Information (the "Aggregated Data"). AstraZeneca may use the Aggregated Data for any lawful purpose, including but not limited to: clinical research, market research and clinical publications. It may also share it with Amgen or with third parties for research purposes and to determine whether certain aspects of the Program require refinement. Any third parties who receive such Aggregated Data must agree that they will not attempt to make the information personally identifiable, such as by combining it with other databases.

Drug Safety

AstraZeneca is legally required to report adverse drug events to Health Canada and to monitor Product complaints. As such, AstraZeneca, its representatives, and the Program Administrator may use and report your Personal Information for these purposes. The Program Administrator may contact you or your physician for additional information to fulfill these obligations.

Consents can be Withdrawn

You may withdraw your consent and authorizations at any time by sending a letter to Innomar Strategies Inc., at 3450 Superior Court, Oakville ON, L6L 0C4. You understand that withdrawal of your consent and authorizations will end further uses and disclosures of your Personal Information and may end your enrolment in the Program. The withdrawal of consent and authorizations will not be retroactive and any activities relating to your Personal Information prior to your withdrawal will not be affected. You may ask any questions about privacy and compliance to the Program Administrator's Privacy Officer by email (connect360@innomar-strategies.com) or telephone (toll-free: 1-833-360-2666).

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