Pr **Osnuvo**™
teriparatide (rDNA origin) injection

ENROLMENT FORM

PATIENT CARE PROGRAM

Email **osnuvoavir@iqvia.com** or Fax to 1-833-455-0972

Questions?
Call us at 1-888-303-8702 or via email osnuvoavir@iqvia.com

Patient sticker

PATIENT INFORMATION

First and last name:____________________

DOB (dd/mm/yyyy):____________________

Address:____________________

City:__________ **Postal code:**________ **Prov.:**____

Sex: ☐ F ☐ M ☐ Other

E-mail:____________________

Phone number:____________________

Best time to call: ☐ AM ☐ PM ☐ Evening

Leave a voicemail? ☐ Yes ☐ No

Drug insurance plan: ☐ Public ☐ Private

Caregiver information (optional)

Allowing the caregiver to also receive the information sent by the program

First and last name:____________________

E-mail:____________________

I HAVE READ, UNDERSTOOD AND ACCEPTED THE TERMS AND CONDITIONS ON THE BACK OF THIS FORM

____
Patient signature

Date of signature (dd/mm/yyyy):____________________

MEDICATION COVERAGE

ODB Patient (Ontario)

Patient qualifies for Osnuvo ODB criterias

☐ Yes (LU code 635 needed on prescription) ☐ No

RAMQ Patient (Quebec)

Patient meets criterias for médicament d' exception ☐ Yes ☐ No

The request was sent to RAMQ: ☐ Yes ☐ No

(date): ____________________

The request is: ☐ Approved ☐ Denied ☐ Waiting on response

Private Insurance

Insurer's name (if available): ____________________

Is Prior Authorization (PA) required? ☐ Yes ☐ No ☐ Unknown

If PA is required, was it sent to insurer: ☐ Yes ☐ No

The request is: ☐ Approved ☐ Denied ☐ Waiting on response

PRESCRIBER INFORMATION

First and last name:____________________

Address:____________________

City:__________ **Postal code:**________ **Prov.:**____

Phone number:____________________

Fax number:____________________

E-mail:____________________

☐ I hereby certify that the patient has stated having read, understood, and accepted the Program's Terms of Use as described on the reverse side of this form.

☐ I hereby certify that the patient has stated having read, understood, and accepted the terms of the Consent regarding their personal information as described on the reverse side of this form.

PRESCRIPTION

This prescription is valid for a period of 30 months.

If prescription information is not provided below, patient has received written prescription.

Rx

☐ **Osnuvo** (teriparatide inj., rDNA origin) 600 mcg/2,4 mL
20 mcg as a subcutaneous injection DIE
Qty: 1 cartridge (28 doses) **Refills**: ________ months*

To the pharmacist: No substitution

☐ **TERROSA Pen** - Only pen to be used with Osnuvo; reusable for the entire treatment duration

☐ **Pen needles - Gauge 29G - 31G, 5mm (maximum 12.7mm)**
Qty: 100 **Refills**: ________

* Maximum lifetime exposure to teriparatide is 24 months. Following cessation of therapy, patient may continue on other osteoporosis therapies.

I authorize STI Technologies Limites to be my designated agent to forward this prescription to the pharmacy chosen by the patient. This prescription represents the original prescription drug order for the patient.

I hereby certify that I am prescribing Osnuvo for this patient in accordance with its intended use, contraindications, warnings and precautions as outlined in the Product Monograph.

____
Physician signature **License #**

Date of signature (dd/mm/yyyy):____________________

PATIENT CARE PROGRAM

Fax: 1-833-455-0972 | Phone: 1 888 303-8702 | E-mail: osnuvoavir@iqvia.com

PROGRAM TERMS AND CONDITIONS

The PrOsnuvo™ Patient Care Program (the "Program") is sponsored by Avir Pharma Inc. ("Avir") and is offered with the support of service providers retained by Avir (the "Service Providers"). The Program provides patient assistance and reimbursement support for the Osnuvo product. This Program is intended for residents of Canada who have been prescribed the Osnuvo product by their physician. Patients enrolled in the Program may receive assistance to determine their eligibility for reimbursement for the Osnuvo product or their eligibility for other financial assistance options. The Program offers these benefits at no cost to enrolled patients; however, Avir reserves the right to change the Program's eligibility criteria, change the scope of the services provided, change Providers, or cancel the Program entirely.

WITH RESPECT TO THE CONTENT AND INFORMATION PROVIDED BY THE PROGRAM AND ITS THIRD-PARTY SERVICE PROVIDERS, YOU UNDERSTAND THAT THE CONTENT AND THE SERVICE ARE PROVIDED "AS IS" WITHOUT ANY EXPRESS OR IMPLIED CONDITION OR WARRANTY OF ANY KIND, AND YOUR RELIANCE UPON ANY CONTENT OR SERVICE OBTAINED OR USED BY YOU, IS SOLELY AT YOUR OWN RISK. IN NO EVENT SHALL THE PROGRAM SPONSOR BE LIABLE TO YOU FOR ANY AND ALL DAMAGES INCLUDING DIRECT, COMPENSATORY, INDIRECT, INCIDENTAL, CONSEQUENTIAL, SPECIAL, EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATING TO THE PROGRAM.

By using the Program, you agree to receive electronic and telephone communications from Avir and its Service Providers regarding your participation in the Program or for the purpose of collecting additional information in connection with the Program. You may withdraw your consent to such communications at any time by contacting osnuvoavir@iqvia.com.

CONSENT REGARDING YOUR PERSONAL INFORMATION

We would like to obtain your consent regarding the personal information collected about you as part of the Program, the nature of which is described on the front of this form. Please ensure you understand each element of the consent. If you have any questions, please contact Avir at osnuvoavir@iqvia.com.

Your consent, once given, will remain in effect for as long as you participate in the Program. You may revoke your consent at any time by contacting Avir at osnuvoavir@iqvia.com. however, you understand that if you revoke your consent, you will no longer be able to benefit from the assistance provided by our Program for your reimbursement claims.

Avir and its Service Providers may retain your personal information for the period required to deliver the assistance provided under the Program and to comply with applicable laws. Avir and its Service Providers may disclose your personal information outside of Quebec to administer the Program. For more information on how Avir collects, uses, and retains personal information, as well as your rights to withdraw consent, access your data, and your rectification right, please consult Avir's Privacy Policy available on Avir's website at www.avirpharma.com. If necessary, you can contact Avir's person in charge of the protection of personal information by email at confidentialite@labriva.com.

I hereby consent to the following:

- personal information about me may be collected by my physician at the time of my enrollment in the Program through this form, as well as by Avir and/or its Service Providers, electronically and/or by telephone, as part of any follow-up;
- Avir may disclose my personal information to the following people and is authorized to collect my personal information from these people: my physician, pharmacist, caregivers and other healthcare providers; Avir's Service Providers; my insurance provider; and regulatory authorities. I authorize and direct each of these parties to disclose my personal information to Avir and its Service Providers for the purposes of the Program;
- my personal information may be used, disclosed and retained by Avir and its Service Providers for the following purposes: my enrollment in the Program; administration of the Program; review of my insurance coverage and verification of my eligibility for coverage; renewal of my coverage and/or other financial assistance options; verification of the accuracy of this information; and to report to regulatory authorities any adverse events related to the use of the Osnuvo product;
- my personal information may be used by Avir for other purposes, including for statistical purposes, provided that any information that could identify me is removed;
- my personal information may be used or disclosed to any person to the extent that disclosure is required by law or court order.

Please forward this form by fax (1-833-455-0972) or email (osnuvoavir@iqvia.com)

Note for the pharmacist:

List of TERROSA Pen ordering information:

Kohl & Frisch: 168912
McKesson: 179048
PJC: 755440
Familiprix: 192247
Shoppers Drug Mart: 628103457004
Pharmaplus: 457103

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