Osnuvo™ Patient Care Program Enrolment Form

Pr Osnuvo™
teriparatide (rDNA origin) injection

AVIR Pharma Inc. is pleased to introduce the Osnuvo Patient Care Program ("Program"). A caseworker will be available to support patients starting Osnuvo therapy by offering reimbursement services, financial support, and injection training.

To enroll your patient please fax this form to: 1 833 455-0972 or email: osnuvoavir@iqvia.com and include a copy of the prescription

PATIENT INFORMATION

Does the patient have a caregiver? ◯ Yes ◯ No

Gender: ◯ Female ◯ Male

First name Last name

Date of birth (dd/mm/yyyy)

Address

City / Province / Postal code

Preferred phone

Best time to reach you: ◯ Morning ◯ Afternoon ◯ Evening

Leave a message? ◯ Yes ◯ No

Alternate phone

Email

Preferred language

Health insurance: ◯ Public ◯ Private ◯ Both

Health card number

Private insurance name (if applicable)

The patient is required to review and sign the reverse of this form to confirm they have read and understood the Terms and Conditions.

PHYSICIAN INFORMATION

First name Last name

Address

City / Province / Postal code

Phone Fax

Email

Other information / office stamp

PRESCRIPTION INFORMATION

New to teriparatide? ◯ Yes ◯ No

Injection training required? ◯ Yes ◯ No

I wish to be notified before the patient mentioned above starts their injection training: ◯ Yes ◯ No

Please provide your patient with a written prescription as the pharmacy requires the original prescription.

Osnuvo subcutaneous injection (250 mcg/mL)
20 mcg once daily

℞

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

Physician name Date (dd/mm/yyyy)

◯ I consent to the Program contacting me with regard to the above-noted patient to assist in administering the Program.

Patient Consent/Terms and Conditions of the Program

The Osnuvo Patient Care Program is a program sponsored by Avir Pharma Inc., the Program Sponsor, for patient assistance and reimbursement support for the product OSNUVO. This Program and related services are intended for and directed to residents of Canada, who have been prescribed Osnuvo by their physician.

Eligible patients who are enrolled in the Program are offered the opportunity to receive educational materials on the management of their condition and help in investigating reimbursement or eligibility for other financial assistance options. In determining your eligibility, you acknowledge that the Service Provider may need to request proof of family income as per applicable provincial or Program Sponsor criteria.

The Program offers these benefits at no cost to enrolled patients; however, the Program Sponsor reserves the right to change the Program's eligibility criteria, change the scope of the services provided, change the Service Provider (currently STI Technologies Limited), terminate your use of the services and your enrollment in the Program, and/or cancel the Program entirely.

Your personal information provided to the Program, during this initial enrolment and/or during any follow up, through telephone calls or otherwise, may be collected, used, disclosed and stored by the Service Provider of the Program on behalf of the Program Sponsor for the purposes of: (1) enrolling you into the Program and monitoring your eligibility for the Program; (2) administering the Program; (3) investigating insurance coverage or eligibility for coverage and/or other financial assistance options with respect to OSNUVO; and (4) verifying the accuracy and completeness of such Information.

By applying for or enrolling in the Program you hereby consent to the Service Provider collecting and using, for the purposes previously described, Information from your prescribing physician, insurance company, pharmacist, caregivers and other healthcare providers and disclosing any Information to these sources and any third-party service providers as the Service Provider considers necessary for the purposes of the Program. You also hereby consent to, authorize and direct each of these sources of information to disclose Information to the Service Provider, again solely for the purposes of the Program.

Further, the Program Sponsor, and its applicable third-party service providers, will receive your personal information in the case of an adverse drug event, or as otherwise required by law, as the Program Sponsor must report to health authorities. Aggregate data containing no personal identifying information may also be provided to the Program Sponsor at any time.

In addition to the above, you understand, accept, and agree that your information may be used or disclosed to any party to the extent such disclosure is required by applicable law, regulation or court order.

That being said, your Information will be retained only for as long as is needed to fulfill the purposes of the Program for which it was collected and in order to comply with applicable laws. Industry standard safeguards will be used to protect the security of the Information that is collected.

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.

A copy of the Service Provider's policies and practices regarding personal information, and a copy of the Program Sponsor's full Terms of Use for this Program, shall be made available to you either electronically, by mail, or in person.

In order to proceed, the Service Provider requires your consent. In providing your consent you acknowledge that you have understood what has been stated and that you agree to same. Once your consent has been received, this authorization and direction is valid for as long as you receive OSNUVO treatment, and for a reasonable time period thereafter, or until you revoke your consent. You can revoke your consent at any time by contacting the Service Provider; however, you understand that if you revoke this consent, authorization and direction, you will no longer receive services from the OSNUVO Program.

By signing below, I wish to participate in the program as described and informed by my treating physician and I have read and understood the Terms and Conditions of the Program above.

☐ **Verbal consent obtained from the patient identified on this form.**

Patient signature

Patient name **Date (dd/mm/yyyy)**

PLEASE FAX OR EMAIL THIS FORM AND A COPY OF THE PRESCRIPTION TO:
1 833 455-0972 OR OSNUVOAVIR@IQVIA.COM