PrCAYSTON® (aztreonam for inhalation solution) PRESCRIPTION AND ENROLMENT FORM

When completed and signed, please fax this form to **1-855-642-6099**.

PATIENT INFORMATION

PATIENT NAME (Please print above the line) ☐ MALE ☐ FEMALE

HEALTH CARD NUMBER | DATE OF BIRTH (DD/MM/YYYY)

STREET ADDRESS

CITY | PROVINCE | POSTAL CODE

TELEPHONE NUMBER | ALTERNATE TELEPHONE NUMBER

DRUG PLAN INFORMATION (for reimbursement assistance)

PATIENT HAS ACCESS TO:

☐ PUBLIC PROGRAM (e.g., Trillium, ODB, Blue Cross, BC Pharmacare, RAMQ) ☐ PRIVATE PLAN ☐ CASH PAYMENT

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURER

PLAN/POLICY/HCNI #

MEMBER NAME

DATE OF BIRTH (DD/MM/YYYY)

SECONDARY INSURANCE

NAME OF INSURER

PLAN/POLICY/HCNI #

MEMBER NAME

DATE OF BIRTH (DD/MM/YYYY)

PRESCRIBING PHYSICIAN INFORMATION

PHYSICIAN NAME

HOSPITAL/CLINIC NAME

STREET ADDRESS

CITY | PROVINCE | POSTAL CODE

TELEPHONE | FAX

MEDICAL AND PRESCRIPTION INFORMATION

CAYSTON 75 MG TID BY INHALATION X 28 DAYS FOLLOWED BY A 28-DAY DRUG-FREE INTERVAL

REPEAT: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

IS THIS THE INITIAL COURSE OF **CAYSTON** FOR THIS PATIENT?

☐ YES ☐ NO

X

PRESCRIBING PHYSICIAN'S SIGNATURE

LICENSE NUMBER | DATE (DD/MM/YYYY)

My signature below confirms I acknowledge having read and I agree with the terms and conditions of the **Patient Enrolment and Consent provided on page 2** of this form.

X

PATIENT/LEGAL GUARDIAN SIGNATURE | DATE (DD/MM/YYYY)

For questions regarding CAYSTON please call 1-855-517-6387
To report adverse events: 1-866-207-4267
(Gilead Sciences Canada Inc., Medical Information)

GILEAD
Advancing Therapeutics. Improving Lives.

PrCayston®
aztreonam for inhalation solution | 75 mg

PrCAYSTON® (aztreonam for inhalation solution) PRESCRIPTION AND ENROLMENT FORM

PATIENT ENROLMENT AND CONSENT

By signing this Form, I hereby authorize my Physician or healthcare professional to submit this completed enrolment form to the **CAYSTON** AIR Program™ (the "**Program**"), and I acknowledge that by doing so, I will be enrolled in the Program. I understand that the Program is a patient assistance program provided by Gilead Sciences Canada, Inc. ("**Gilead**") and administered by an independent third party contracted by Gilead for Canadian patients who have been prescribed **PrCAYSTON®** (aztreonam for inhalation solution) ("**CAYSTON**"). The Program provides, if applicable, reimbursement assistance, co-payment assistance and ongoing follow-up of my **CAYSTON** prescription (collectively, the "**Services**"). I understand that I may also enrol myself in the Program by telephone or fax, if my Physician has prescribed **CAYSTON** for me. I confirm that the information I provide to the Program is true.

I consent to receiving, including but not limited to, electronic, telephone and facsimile communications from the Program's administrator and personnel, for the purposes of determining my eligibility for the Program, conducting Program-related activities and for delivering the Program services to me. Email communications may be sent to the address I have provided. I understand I can withdraw my consent at any time, by so advising the Program administrator. I understand that Gilead and/or the independent third party administrator have the right to contact me in the event an adverse event is reported, to further follow up if required, including reporting to Health Canada.

I understand and acknowledge that in order to enrol in the Program and receive Program Services, certain personal and medical information about me ("**Personal Information**"), such as personal medical, financial and insurance coverage information will be collected, documented, recorded and/or disclosed from me and my Prescribing Physician, pharmacist, nurse, insurer, government agency, employer or other sources ("**the Parties**") as necessary to ensure the accuracy and completeness of this application and to obtain information as required to provide me the Program Services. Accordingly, I authorize my insurer to share my Personal Information with the Program, including my coverage eligibility information and authorize the Program to investigate and determine my insurance benefit potential on my behalf. I further authorize the Prescribing Physician to disclose to the Program Personal Information related to my relevant medical condition as may be required by my insurer to process my insurance claim(s). By submitting my information to the Program, I agree that it will be governed by the Program administrator's privacy policy, a copy of which can be obtained by calling the Program. I authorize the Program to contact me in order to provide me with follow-up services for my prescription of **CAYSTON** and other information required for the administration of the Program.

I acknowledge that except as specified above or as required by law, my Personal Information will not be shared with other individuals. However, I understand that Personal Information may be collected, used and stored on paper and/or electronic systems by the Program's independent third party administrator and other service providers (e.g., information technology providers) that may store or process my Personal Information outside of Canada where it will be subject to local legislation, which may require disclosure of my Personal Information to governmental authorities under different circumstances than would Canadian legislation. I agree that my information may be rendered anonymous and aggregated with that of other patients and shared with Gilead and its affiliates for purposes of reporting on, monitoring and evaluating the Services. I further understand that my Personal Information will be protected using industry standard safeguards, and will be retained only for the time required to fulfil the purposes of the Program and to comply with applicable laws. I understand that I may contact the Program at any time to update or access my Personal Information, modify or withdraw my consent (in part or in full), express a privacy-related concern, or to inquire about the privacy practices of the Program. However, I understand and acknowledge that should I modify or withdraw my consent, the ability to deliver the Program Services to me may be limited.

Gilead may without prior notice to the Patient, at its sole and absolute discretion and at any time, change the Program's eligibility criteria, change the scope of the Services provided, and/or cancel the Program in its entirety.

CAYSTON (aztreonam for inhalation solution) is indicated for the management of cystic fibrosis (CF) patients with chronic pulmonary *Pseudomonas aeruginosa* infections. **CAYSTON** (aztreonam for inhalation solution) is contraindicated in patients with a known allergy to aztreonam or to any ingredient in the formulation or any components of the container. Please see the product monograph for a complete list of warnings and precautions, adverse events, patient selection criteria and dosage and administration information.

The **CAYSTON®** AIR Program™ is sponsored by Gilead Sciences Canada, Inc. and implemented by an independent third party.

Reimbursement under the **CAYSTON** AIR Program™ cannot be guaranteed.

GILEAD
Advancing Therapeutics.
Improving Lives.

PAAB Member R&D

PrCayston®
aztreonam for inhalation solution | 75 mg