

# Pr CAYSTON® (aztreonam for inhalation solution) PRESCRIPTION FORM

**When completed and signed, please fax this form to 1-866-949-9923.**

For questions regarding CAYSTON or to report adverse events, please contact Gilead Sciences Canada, Inc. Medical Information at 1-866-207-4267.

For questions regarding CAYSTON distribution, dispensing, or use with Altera™ Nebulizer System, please contact Innomar Specialty Pharmacy ("Innomar") at 1-866-949-9918.

## 1. PATIENT INFORMATION

If an item does not apply, please write "N/A".

PATIENT'S NAME (PLEASE PRINT ABOVE LINE)

DATE OF BIRTH (DD/MM/YY)

HEALTH CARD NUMBER

STREET ADDRESS

CITY PROVINCE POSTAL CODE

( ) ( )

TELEPHONE NUMBER ALTERNATE TELEPHONE NUMBER

## 2. COVERAGE AND INSURANCE

If you have insurance, please complete this section. If you do not, please write "NONE" above the first line below, and proceed to Section 3.

### A. PRIMARY HEALTH INSURANCE COMPANY

HEALTH INSURANCE COMPANY NAME (PLEASE PRINT ABOVE LINE)

CARRIER ID POLICY/GROUP NUMBER

CLIENT IDENTIFICATION/CERTIFICATE NUMBER

SUBSCRIBER'S NAME

### B. SECONDARY INSURANCE

HEALTH INSURANCE COMPANY NAME

CARRIER ID POLICY/GROUP NUMBER

CLIENT IDENTIFICATION/CERTIFICATE NUMBER

SUBSCRIBER'S NAME

## 3. PRESCRIBING PHYSICIAN INFORMATION

PHYSICIAN'S NAME (PLEASE PRINT ABOVE LINE)

STREET ADDRESS

CITY PROVINCE POSTAL CODE

( ) ( )

TELEPHONE NUMBER FAX NUMBER

## 4. MEDICAL AND PRESCRIPTION INFORMATION

DIAGNOSIS

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

PRESCRIBING PHYSICIAN'S SIGNATURE

LICENSE NUMBER

DATE

## 5. APPLICANT CONSENT

I verify that the information that is provided in this prescription form is complete and accurate. I understand that upon receipt of the prescription form, Innomar will contact me. Additional information may be required.

I understand that all personal information collected will be used solely for the purposes of dispensing CAYSTON, and will not be disclosed to any third party other than authorized agents, employees, and contractors (who have agreed to abide by Innomar's privacy policies) and my physician.

I understand that the file containing my information will be kept at the Innomar office at 3450 Harvester Road, Burlington, Ontario, L7N 3M7 and I, in accordance with applicable legislation, will have the right to access such file and rectify any errors contained in the file.

I understand that any calls to and from Innomar may be monitored or recorded and will be treated as strictly confidential in compliance with federal and provincial privacy legislation.

SIGNATURE

DATE

If the person signing is not the patient named above, please indicate the basis of authority for consent.

CAYSTON (aztreonam for inhalation solution) is indicated for the management of cystic fibrosis (CF) patients with chronic pulmonary *Pseudomonas aeruginosa* infections. Demonstration of longer-term safety and efficacy of CAYSTON is limited to uncontrolled, open-label clinical trial data obtained over nine cycles of therapy. Safety and efficacy have not been demonstrated in patients with FEV<sub>1</sub> <25% or >75% predicted or in patients colonized with *Burkholderia cepacia* complex. Sputum culture and susceptibility testing performed periodically will provide information on changing microbial flora and the possible emergence of bacterial resistance. Clinical studies with CAYSTON did not include sufficient numbers of patients aged 65 years old and over to determine whether they responded differently from younger patients. Safety and efficacy have not been studied in patients under the age of 6 years.

CAYSTON is a registered trademark of Gilead Sciences, Inc. and its related companies.

