ORGANON ASPIRE™
Compassionate Program

ENROLLMENT FORM

Tel: 1-866-750-6048
Fax: 1-888-290-6061
Email: organonaspirecpsp@innomar-strategies.com
Monday to Friday, 8 a.m. to 8 p.m. EST

Objectives and Purpose of the Program

The **ORGANON ASPIRE™ Compassionate Program** is pleased to offer you confidential patient-assistance services, free of charge, designed for patients who have been prescribed an Organon Product. Depending on your eligibility or need, you will be offered these services which include the provision of compassionate product and clinic delivery.

Patient Information: To be completed by patient (Please print clearly. Patient signature required.)

First name: Last name:

Date of birth: (DD/MM/YYYY) Gender: ☐ Male ☐ Female ☐ Other

Street address: City: Province: Postal code:

Preferred phone: Best time to reach you: ☐ Morning ☐ Afternoon ☐ Evening

Alternate phone: Leave a message: ☐ Yes ☐ No

Email address: Preferred language: ☐ English ☐ French ☐ Other

Do you have health insurance coverage? ☐ Private ☐ Public ☐ Both Authorization to speak to patient's caregiver: ☐ Yes ☐ No

Caregiver first name: Caregiver last name: Relationship:

If a legally authorized representative consents for the patient, complete the following:

First name: Last name:

Street address: City: Province: Postal code:

Permission to leave a message? ☐ Yes ☐ No

Email address: Relationship to patient:

SEE FULL PATIENT CONSENT TERMS ON REVERSE. PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND THE PATIENT CONSENT TERMS.
I, the undersigned, have read the above Program terms and conditions (the "Terms and Conditions") found on the reverse side of this form and I agree to the collection, use and disclosure of my personal information, including my sensitive personal health information, in accordance with the Terms and Conditions.

Patient's Signature or Legally Authorized Representative's Signature: **Date:** (DD/MM/YYYY)

Prescribing Information: To be completed by prescriber (Please print clearly. Prescriber signature required.)

Name of prescribed drug: Refills:

Diagnosis (required): Strength: Quantity:

Dosage and administration instructions

Prescription information

Special instructions

Prescriber Certification
I am requesting that the Organon product, described in the Prescribing Information section above, be supplied at no cost to my patient named above, in the event that the ORGANON ASPIRE™ Compassionate Program is unable to find reimbursement for this product. I understand that patient eligibility for provision of product at no cost to the patient is based on established financial needs.

Prescriber Information: To be completed by prescriber (Please print clearly. Prescriber signature required.)

Prescriber first name: Prescriber last name:

License number: Specialty:

Clinic name (if applicable):

Street address: City: Province: Postal code:

Phone number: Fax number:

Email address: Permission to leave a message at number provided: ☐ Yes ☐ No

Other Information / office stamp

SEE FULL PRESCRIBER CONSENT TERMS ON REVERSE. PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND THE PRESCRIBER CONSENT TERMS. Please read the information included on the reverse side of this Patient Enrollment Form to obtain a full description of the Program and, if you agree, sign below.

Prescriber Signature: **Date:** (DD/MM/YYYY)

Please fax this completed form to 1-888-290-6061 or email to organonaspirecpsp@innomar-strategies.com

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Prescriber Disclosure and Consent:

Please read the information included in the Patient Enrollment Consent section to obtain a full description of the ORGANON ASPIRE™ Compassionate Program and, if you agree, sign the form.

- I, the undersigned, have read the Terms and Conditions. I understand the services offered by the Program and I represent that (i) I have met with the patient and discussed the Program with him/her; (ii) the patient understands the Program; (iii) the patient is interested in enrolling in the Program; (iv) the patient has consented to me filling out the form and communicating it to the Program Administrator and, when applicable, to any third parties involved in the Program for purposes of enrollment in the Program or its administration (the "**Third Parties Involved**"); (v) the patient was explained that consent for the sharing of coded data with Organon is necessary for the management of the Program; and (vi) the patient agrees to be contacted by the Program Administrator and/or any Third Parties Involved whose services have been retained to initiate and manage his/her enrollment in the Program.
- I understand that, for the purposes of being provided relevant information related to the services offered to the patient, I may be reached using the contact information provided in the 'Prescriber Information' section above by Organon, the Program Administrator and/or any Third Parties Involved, or their agents.
- I understand that prescribing information may be used by the Program Administrator, Third Parties Involved or by Organon or its agents for statistical analysis and research purposes relevant for operational and business planning in a manner which will not allow my identification.
- I understand that my personal information, which I provided, as well as prescribing information that does not allow identifying my patient, may be shared with Organon or its agents for the purposes of the Program assessment, management and enhancement.
- I also consent to be reached, using the contact information provided in the 'Prescriber Information' section above, for the purpose of inquiring about my experience with the Program so that services may be improved, by Organon, the Program Administrator, the Third Parties Involved or their agents.
- I understand that I may request access to the information collected about me to ensure accuracy and correct any mistake or revoke this consent at any time by mailing or faxing a signed request to the Program Administrator at 3470 Superior Court Oakville, ON L6L 0C4, program fax: 1-888-290-6061
- I, the undersigned, certify that my patient's condition is within the indications listed in the current product monograph and that the dosage is appropriate based on my clinical judgment.
- By providing the name and business coordinates of the Nurse, I represent that I have obtained his/her consent to do so for the purpose of the Program.
- I agree to the use and transfer of my name and coordinates to the appropriate public payors to assist with the transfer of my patient into the public program, where applicable.
- I, the undersigned, also agree to the disclosure of appropriate clinical documentation to controllers and auditors contracted by Organon for audit purposes, to the extent that such disclosure is in accordance with the Terms and Conditions.
- I understand that the Program can be terminated or modified at any time.

Patient Enrollment Form/Terms and Conditions of the Program:

PLEASE READ THIS CONSENT FORM CAREFULLY BEFORE SIGNING

The objectives and purposes of the **Program** consist of offering confidential patient-assistance services, free of charge, designed for patients who have been prescribed an Organon Product. Depending on my eligibility or need I will be offered these services which include; the provision of compassionate product and clinic delivery. I understand that the Program can be terminated or modified at any time.

1. What type of personal information is collected and why?

The Program Administrator and, when applicable, any third parties involved in the Program enrollment process or its administration (the "**Third Parties Involved**") need to collect personal information to determine your eligibility for the Program, administer the Program, communicate with you and identify you (for example by asking you questions). The information included on this form will be submitted to either the Program Administrator or any Third Parties Involved by your healthcare provider on your behalf.

In addition, in some cases, your personal information (including financial and health information) may be collected from third parties such as your healthcare provider, health insurer, provincial public payer and your caregiver. For example:

☐ Your medical history and condition and other health information may be obtained from your healthcare provider for the purpose of determining your eligibility to enroll in the Program.

☐ Your health insurance and payment information may be collected from your health insurer for the purpose of assisting you with a reimbursement for which you are eligible.

2. How is your personal information shared?

Third parties assisting with the Program. Your personal information may be exchanged among the Program Administrator, the Third Parties Involved, their agents, your healthcare provider or health insurer, the provincial public payer, nurses, prescribers, pharmacists, the laboratory and your caregiver, when necessary to manage your participation in the Program. For example, your health insurance information may be shared by the Program Administrator or any Third Parties Involved with your insurance provider for the purposes of determining your eligibility for reimbursement.

Program sponsor. Organon, the sponsor of the Program, may receive: (i) coded information (personal information stripped of its direct identifiers such as your name, address, full date of birth or similar information linked to a secret code) necessary to manage patient enrollment as well as for operational and business planning; as well as (ii) aggregated information (personal information combined with the information of other Program participants without the possibility of identifying you) so that it can perform statistical analysis and identify trends in order to improve the Program. It may also receive your personal information, but only when required by law or in the following limited circumstances:

☐ a complaint is received in connection with the Program;

☐ a healthcare provider either has a special request that would require pre-authorization from Organon or has indicated special instructions on an enrollment form requiring Organon's involvement to coordinate the request;

☐ there is an adverse event and Organon needs to follow up with your healthcare provider.

3. Where is your personal information stored and how can you access it?

I understand that the file(s) containing my personal information will be maintained at the offices of the Program Administrator located at 3470 Superior Court Oakville, ON L6L 0C4, program fax: 1-888-290-6061. I may request access to, or correction of, my personal information at any time by contacting the Program Administrator in writing at the following address: at 3470 Superior Court Oakville, ON L6L 0C44.

4. What are your choices?

Participation in the Program is voluntary but to participate, you must agree to the collection, use and disclosure of your personal information as set out in this form.

Withdrawal of consent for participation in Program. If you no longer wish to participate in the Program, you can contact your healthcare provider, health insurer(s) or the Program Administrator by telephone (1-866-750-6048), by mail, fax or email (see above). Upon receiving your request, you will no longer be enrolled in the Program nor receive assistance with the reimbursement for the product. I hereby confirm that I wish to enroll in the Program, that I have been given the opportunity to discuss the Program with my healthcare provider (i.e., doctor or nurse) and that I have read the above Program terms and conditions and agree to the collection, use and disclosure of my personal information in accordance with this consent form.

Please fax this completed form to 1-888-290-6061 OR EMAIL TO organonaspirecpsp@innomar-strategies.com.

ORGANON

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REVIEWED BY PAAB