HeadStart™
Patient Assistance Program

Fax the completed form to: **1-844-329-6338**
Or email to headstartOFEV@patientassistance.ca
Call toll-free: **1-844-473-6338**

Pr OFEV® nintedanib

ENROLMENT FORM

Clear Form

PATIENT'S Information

Patient Record #: _____

First Name: _____

Last Name: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

☐ Male ☐ Female Date of Birth (dd/mm/yyyy): ____/____/____

Language: ☐ English ☐ French ☐ Other _____

Provincial Health Card #: _____

Preferred Phone: _____ Alternate Phone: _____

May the Program leave a message? ☐ Yes ☐ No

Email: _____

Confirmed Patient Diagnosis: ☐ IPF ☐ Systemic Sclerosis ILD
☐ Progressive Fibrosing ILD

Specify underlying ILD diagnosis: _____

Diagnostic criteria			
Test	Date Completed (dd/mm/yyyy)	Values	Report Attached
HRCT		N/A	☐ Yes
FVC (% predicted)			☐ Yes
QC only criteria			
DL_{CO} (% predicted)			☐ Yes
FEV_1/FVC (%)			☐ Yes

Has an application already been submitted to the province for this patient? ☐ Yes ☐ No If yes, date submitted: _____

By signing below, I confirm my desire to enrol in the HeadStart™ Patient Assistance Program ("Program") administered by McKesson Canada Corporation ("Program Provider") and sponsored by Boehringer Ingelheim (Canada) Ltd., the manufacturer of OFEV®. I hereby consent to the collection, use and disclosure of my personal information by the Program Provider as necessary to provide the services of the Program, including the temporary storage and access of my personal information outside of Canada by the Service Provider for maintenance and support purposes. I understand and consent to the Program Provider contacting my insurer, physician/healthcare provider(s) and spouse (if applicable) to obtain my personal, financial and medical information for the purposes of evaluating my Program eligibility, determining my public and private drug insurance plan benefit eligibility, and managing my Program benefits. I understand that collection, use and disclosure of personal information will be ongoing during my participation in the Program and such personal information will include supporting documentation including financial information to verify insurance coverage or to otherwise arrange for financial coverage for my medication(s), and medical information including laboratory test results and adverse events experienced during my participation in the Program. Despite our mitigation efforts and privacy safeguards, risks of harm and other consequences resulting from a privacy breach cannot be completely eliminated. The Program Provider will contact you with steps you may take to reduce any risks of harm in the event of a privacy breach.

X _____ ____/____/____
Patient's or Authorized Caregiver's Signature Date (dd/mm/yyyy)

_____
Printed Name of Patient or Authorized Caregiver Relationship

PHYSICIAN'S Information

Name: _____

Medical License #: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Phone: _____ Fax: _____

Physician Email: _____

Nurse/Office Contact: _____

Nurse/Office Phone (if different from above): _____

PRESCRIPTION Information

OFEV (nintedanib) capsules
Dose: 150 mg orally **Frequency:** BID
Quantity: 30-day supply (60 capsules)
Special instructions:

_____

_____

☐ **Refills:** _____

In order for HeadStart to provide a bridging supply of OFEV to patients until reimbursement is secured, please attach copies of the applicable reimbursement form and appropriate diagnostic criteria.

☐ **TO THE PHARMACIST**
Please place the following prescription on hold for this patient, to be released as needed pursuant to authorization from the HeadStart Program Nurse Case Manager after consultation with my office.
OFEV (nintedanib) capsules
Dose: 100 mg orally
Frequency: BID
Quantity: 30-day supply (60 capsules)
☐ **Refills:** _____

I hereby acknowledge that I am the patient's attending physician, and confirm that the patient has been prescribed OFEV (nintedanib) as per the Product Monograph. I authorize the HeadStart Patient Assistance Program to be my designated agent to forward this prescription by fax or other mode of delivery to the pharmacy chosen by the above named. This prescription represents the original prescription drug order. The chosen pharmacy is the only intended recipient and there are no others. The original prescription has been invalidated and securely filed, and will not be transmitted at another time.

X _____ ____/____/____
Physician's Authorization Date (dd/mm/yyyy)

ADJUNCT MEDICATION/BLOODWORK

As needed and pursuant to authorization from the prescribing physician.

☐ **Antidiarrhea:** loperamide 2 mg tablets

Recommended dose for acute diarrhea: 2 tablets orally followed by 1 tablet after every subsequent loose stool.

Daily dosage should not exceed 8 tablets (16 mg) in 24 hours.

Quantity: 45 tablets.

☐ **Refills:** _____ ☐ **Patient given requisition for bloodwork**

We respect your right to privacy. Any personal information or personal health information provided to the Program Provider directly by you or indirectly by you through your insurer, physician/healthcare provider(s) or spouse will be maintained in strict confidence and used solely to provide you with the OFEV product and services of the HeadStart Patient Assistance Program ("Program"). The Program Provider may disclose your personal information on a confidential basis to authorized agents, employees and regulatory agencies as required for delivery of the Program, to assess, audit and/or improve the Program, for regulatory purposes and to comply with applicable laws. For more information about the privacy practices for the Program or to update or access your personal information, modify or withdraw your consent, or express a privacy-related concern, please contact the Program at 1-844-473-6338. Please note that if you modify or withdraw your consent, the ability of the Service Provider to deliver the Program may be limited. The Program Provider is McKesson Canada Corporation, 6355 Viscount Road, Mississauga, ON, L4V 1W2. The privacy officer for the Program Provider is Antonietta Pastorelli and you may consult the privacy policy of the Program Provider at https://www.mckesson.ca/privacy.

REMINDER: The Enrolment Form cannot be processed without the physician's authorization and the patient's or authorized caregiver's consent.

If verbal consent received in event signature cannot be obtained:

I, _____, certify that the Patient's legal representative has read, understood and has been provided the opportunity to ask questions regarding the Patient Consent and Privacy Information herein.

_____ (Patient/Representative) provided his/her verbal consent with the collection, use and disclosure of his/her Personal Information in accordance with those terms on ____/____/____ (Date).

ILD=interstitial lung disease; IPF=idiopathic pulmonary fibrosis.

REVIEWED BY PAAB

MEMBER OF INNOVATIVE MEDICINES CANADA

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