

PATIENT INFORMATION

FIRST NAME: _____

LAST NAME: _____

DATE OF BIRTH (DD/MM/YYYY): _____ SEX: _____
 MALE FEMALE

DD / MM / YYYY

ADDRESS: _____

CITY: _____

PROVINCE: _____

POSTAL CODE: _____

PREFERRED PHONE NUMBER: _____

EMAIL: _____

BEST TIME TO CALL: _____ PREFERRED LANGUAGE: _____
 MORNING ENGLISH
 AFTERNOON FRENCH
 EVENING OTHER _____

INSURANCE COVERAGE

PRIVATE PUBLIC NONE UNKNOWN

PATIENT CONSENT

I HEREBY CONFIRM THAT I HAVE READ AND UNDERSTAND THE PATIENT CONSENT INFORMATION ON THE REVERSE OF THIS FORM, AND THAT I AGREE TO PARTICIPATE IN THE IPSEN CARES[®] PROGRAM.

_____ DD / MM / YYYY
 PATIENT'S SIGNATURE DATE (DD/MM/YYYY)

VERBAL CONSENT OBTAINED

PRESCRIPTION INFORMATION (Physician to complete)

CABOMETYX[®] (cabozantinib) AS MONOTHERAPY:
 aRCC: RECEIVED PRIOR THERAPY
 aRCC: TREATMENT-NAÏVE WITH INTERMEDIATE OR POOR RISK
 HCC: PREVIOUSLY TREATED WITH SORAFENIB
 DTC: RECEIVED PRIOR VEGF-THERAPY AND RAI REFRACTORY/INELIGIBLE (>18 YRS)

CABOMETYX[®] (cabozantinib) IN COMBINATION:*
 aRCC IN COMBINATION WITH NIVOLUMAB: 1L ALL RISK GROUPS
 * The services offered through enrolment only apply to CABOMETYX[®].

DO NOT DISPENSE AT THIS TIME.
 A follow-up prescription will be required to dispense.

DOSE (ORAL, ONCE DAILY):
 60 MG (AS MONOTHERAPY) OTHER: _____
 40 MG (IN COMBINATION WITH NIVOLUMAB) OTHER: _____

DATE OF FIRST DOSE (DD/MM/YYYY): DD / MM / YYYY

QTY (# OF TABLETS): 30 REPEATS: _____

OTHER INSTRUCTIONS: _____

PREVIOUS LINES OF THERAPY:
 FIRST _____
 SECOND _____
 THIRD _____
 OTHER _____

 PHYSICIAN'S SIGNATURE

_____ DD / MM / YYYY
 PHYSICIAN'S NAME (PRINT) DATE (DD/MM/YYYY)

PHYSICIAN/OFFICE INFORMATION

PHYSICIAN/HOSPITAL/CLINIC NAME: _____

PHYSICIAN LICENSE #: _____

STREET: _____

CITY: _____ PROVINCE: _____

POSTAL CODE: _____ TELEPHONE: _____

FAX: _____

EMAIL: _____

DELIVERY LOCATION

SAME AS HOME ADDRESS ABOVE

NAME: _____

STREET: _____

CITY: _____ PROVINCE: _____


POSTAL CODE: _____ TELEPHONE: _____

CONSENT

I HEREBY CONFIRM THAT I HAVE OBTAINED CONSENT OR, WHERE NECESSARY, HAVE ON FILE AN AUTHORIZATION FROM THE PATIENT TO DISCLOSE AND AUTHORIZE FURTHER DISCLOSURE OF THE PATIENT'S HEALTH AND INSURANCE INFORMATION FOR THE PURPOSES OF ENROLMENT AND PARTICIPATION IN THE IPSEN CARES[®] PROGRAM.

_____ DD / MM / YYYY
 PHYSICIAN/HEALTHCARE PROFESSIONAL DATE (DD/MM/YYYY)
 SIGNATURE

 To enrol, please fax completed form, toll-free, to:
1-844-686-0661

 For more information about the program,
Call 1-855-215-2288 (Choose option 1)
 Monday through Friday, 8 a.m. to 8 p.m. ET (5 a.m. to 5 p.m. PT)

 Forms completed electronically can be sent via email to:
ipsencares.canada@ipsen.com

IPSEN CARES® is a confidential support program that provides services to patients for whom CABOMETYX® therapy has been prescribed.

- Reimbursement specialists assist with access to coverage and help patients to apply for other types of financial assistance, when appropriate.
- Reminder and counselling calls to assist patients to take their medication as directed.

Consent to disclosure and use of personal information/personal health information

The IPSEN CARES® program (“Program”) is sponsored and offered by IPSEN Biopharmaceuticals Canada Inc. (“IPSEN”) and administered by a third-party service provider selected by IPSEN (“Service Provider”). By signing this enrolment form, you agree to enrol in the Program and consent to being contacted by a program coordinator in connection with the administration of the Program services.

You acknowledge that the Service Provider may require your personal information, including personal health information (“Personal Information”), to administer the Program and may contact you, your physician or other healthcare professional for this purpose. You authorize your physician or other healthcare professional to disclose Personal Information to the Service Provider and agree that this authorization includes any initial disclosure of Personal Information on enrolment in the Program as well as ongoing communication between your physician and the Service Provider during the course of your participation in the Program. You acknowledge that over the course of your participation in the Program, the Service Provider may disclose Personal Information to your physician or other healthcare professional relating to the services you receive under the Program, including the results of surveys and/or health- or treatment-related information.

You authorize the Service Provider to collect data relating to you and to disclose the data in an anonymized or aggregate form to IPSEN for the purpose of monitoring and/or improving the Program, as well as for scientific publications and to conduct clinical or market research, in accordance with applicable law.

By signing this form, you confirm that you have read the Program patient consent information, that you have had the opportunity to ask your physician and/or other healthcare professional any questions you may have about the Program, and that all questions you have asked have been answered to your satisfaction.

By signing this form, you also confirm your understanding of and consent to the following:

In addition to the possibility of being contacted as described above, and on the front of this form, you also agree that you may be contacted by the Service Provider, IPSEN, an agent or collaborator of IPSEN, or a third party designated by IPSEN for the purpose of

- customer satisfaction surveys with respect to the Program, or
- participation in a future study, and you consent to your contact details being provided to IPSEN, IPSEN’s agent or collaborator, or a third party designated by IPSEN for this purpose.

You further agree to allow the Service Provider to review your medical record to assess your eligibility to participate in upcoming clinical research studies. If you are deemed eligible, you agree that the Service Provider may contact you directly or, where applicable, provide your contact details to IPSEN, IPSEN’s agent or collaborator, a third party designated by IPSEN to inquire about your interest in participating in such research studies. You are under no obligation to agree to participate in any such study in order to receive services under the Program.

The Service Provider may de-identify, aggregate (combine with other data) and/or anonymize your Personal Information to conduct analyses for commercial, research/publication purposes or to improve the Program. In such case, Ipsen ensures that your Personal Information is protected.

Disclosure

By signing this form you also confirm your understanding of and consent to the following:

From time to time, the Program may be required to disclose your Personal Information to third parties. For example, Personal Information regarding drug-related adverse events may be collected by the Service Provider or an agent of IPSEN and submitted to Health Canada, a regulatory authority that is involved in collecting reports of drug-related adverse events. However, the information provided will not disclose your identity but will include details such as your initials, your date of birth, your age, weight, height and other relevant incidental information, and any suspected adverse event you may have experienced. You consent to being contacted by the Service Provider or an agent of IPSEN to obtain further information or clarification regarding any adverse event you may experience. Similarly, you consent to the Service Provider or an agent of IPSEN contacting your physician or other healthcare professional for the same purpose.

Some of the third parties to whom your Personal Information may be disclosed may not be in Canada, so your Personal Information may be transmitted and/or stored outside of Canada. Examples of such third parties may include pharmacies, insurance companies or publicly-funded drug payment programs. Your Personal Information will be stored securely and confidentially, with access to your Personal Information restricted to authorized personnel. Safeguards will be used to protect your Personal Information against unauthorized access, disclosure, and/or use.

To the extent that the Program provides you with assistance in obtaining coverage or reimbursement for the acquisition cost of CABOMETYX® tablets from your provincial drug benefits program, insurance company or other funding source, the Program will make all reasonable efforts but cannot guarantee success in obtaining such coverage or reimbursement.

Changes to the Program

You understand and agree that IPSEN may, at any time and without advance notice, modify the services provided by the Program, modify the eligibility requirements to obtain such services, discontinue the Program in whole or in part, and terminate assistance provided under the Program.

From time to time, IPSEN may appoint a new Service Provider to assist in the administration of the Program. You authorize IPSEN to transfer your personal information/personal health information to any new party selected by IPSEN in relation to the administration of the Program.

Consent to be contacted

In addition to the possibility of being contacted as described above, and on the front of this form, you also agree that you may be contacted by the Service Provider or an agent of IPSEN for the purpose of customer satisfaction surveys with respect to the Program, and you consent to your contact details being provided to IPSEN’s agent for this purpose.

Requesting access and withdrawing consent

You have the right to revoke your consent at any time or request access to and/or correct the Personal Information that the Service Provider, IPSEN or IPSEN’s agent have on file about you and to obtain information on how the Personal Information has been used, subject to any legal restrictions. To revoke consent or request access, you can contact the Program at 1-855-215-2288 or IPSEN at the following address: Privacy Officer, IPSEN Biopharmaceuticals Canada Inc., 5060 Spectrum Way, Mississauga ON L4W 5N5. You understand that the Personal Information already collected about you and/or disclosed before you revoked consent will be retained. You understand your participation in this Program is not required for you to have access to CABOMETYX® and you do not have to consent to this authorization. If you choose not to consent, or if you revoke your consent at a later time and thereby withdraw from the Program, you will not be entitled to the services offered by the Program.