AccessLink
a BioScript Solutions service

Fax completed form to: 1-855-278-5182
Tel: 1-888-398-0028 | Email: accesslink@bioscript.ca

Monoferric
Patient Enrolment Form

Patient Information

First Name: _____ Last Name: _____ DOB (MM/DD/YYYY): _____
Phone: _____ Email: _____ Health Card #: _____
Address: _____ City: _____ Prov: _____ Postal Code: _____
Allergies: _____ Patient weight: _____ kg
Insurance Name: _____ Group ID: _____ Certificate ID: _____

Best time for contact: ☐ Morning ☐ Afternoon ☐ Evening | Can the AccessLink team leave you a message? ☐ Yes ☐ No

Authorized Representative (if applicable)
Name: _____ Phone: _____ Email: _____

☐ **Patient has been informed of the infusion fee ($235). All prices are subject to change without notice.**

Verbal consent received by: _____ | Date of consent (MM/DD/YYYY): _____

Medical History (Please complete next page)

Diagnosis: ☐ Iron deficiency anemia ☐ Other: _____

Current Hb Level: _____ g/L Date (MM/DD/YYYY): _____

Is the patient pregnant? ☐ Yes (please indicate any additional protocols) ☐ No
If yes – you acknowledge that as per the Monoferric Product Monograph, Monoferric should not be used during pregnancy and you have discussed the associated risks with the patient/guardian and wish to proceed with treatment as ordered below.

Oral iron therapy tried:
☐ Yes ☐ No

Patient's response to PO iron:
☐ Inadequate response
☐ Intolerance
☐ Contraindicated

Prescription

Monoferric 100mg/mL(Ferric Derisomaltose)

Infusion: Administer Monoferric (select dose below) in 100mL 0.9% normal saline as per manufacturer recommendations

☐ **500mg** ☐ **1,000mg** ☐ **1,500mg** ☐ **Other**: 20mg/kg x ____ kg = _____ mg
≤ 1,000mg must be infused over at least 20 minutes
>1,000mg must be infused over at least 30 minutes

Notes:
- Single doses above 1,500mg are not recommended. If ordered iron dose exceeds 20mg iron/kg body weight, the dose will be split into two infusions spaced at least one week apart.
- It is recommended whenever possible to give 20mg Iron/kg body weight in the first infusion.

Frequency:
☐ **One-time dose** (No further appointments will be scheduled unless patient's dose exceeds 20mg/kg or 1,500mg and must be split into two infusions at least one week apart.)

☐ **Administer ____ infusions at a frequency of:** ☐ **Weekly** ☐ **Every 2 weeks** ☐ **Monthly** ☐ **Other:** _____
Clinic nurse will schedule additional appointments until they have been given x number of infusions/injections at the ordered frequency.

Note: Prescribing physician is responsible for ordering and monitoring patient bloodwork and notifying AccessLink when patient no longer requires treatment.

Patient Consent and Signature

☐ Patient or Authorized Representative has consented to being contacted by AccessLink for Drug Navigation Support and agrees to the terms in **Section A and B of this Form**.

Patient (or Authorized Representative) Signature:_____ Date (MM/DD/YYYY): _____

Verbal Consent Received by: _____

Prescriber Authorization

☐ Dr. Allen Lim (015686) ☐ Dr. Melanie Pinchbeck (016259) ☐ Dr. Lori Stead (016226) ☐ Dr. Macolm Wells (018463)
☐ Dr. Rajveer Hundal (017727) ☐ Dr. Amit Dhillon (027340) ☐ Dr. Thomas Krahn (032531) ☐ Dr. Mahmod Mohamed (016859) ☐ Dr. Jan Nilsson (016805)

By signing this form, Prescriber affirms the within information and certifies that: Prescriber has discussed the AccessLink Services with the Patient or Authorized Representative, and they consent to be contacted by AccessLink as described. Prescriber authorizes AccessLink to act as the designated agent for the purposes of forwarding the prescription to the patient's pharmacy of choice. This prescription represents the original of the prescription drug order. The original prescription has been invalidated and securely filed, and it will not be re-transmitted or used elsewhere.

Prescriber Name (Printed): _____ Fax: _____ Phone: _____
Address: _____ Licence #: _____
Prescriber Signature: _____ Date (MM/DD/YYYY): _____

Patient Information

Name: _____ **DOB (MM/DD/YYYY):** _____

Medical History (Continued)

Previously Tried Therapies (or attach a medical history document):

Drug Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication	If inadequate response, Hb levels (g/L) before and after treatment

If Oral Iron Therapy has NOT been used, please provide reason:

- ☐ Oral Iron Therapy is contraindicated due to:
  - ☐ Patient has clinical malabsorption.
  - ☐ Patient has chronic blood loss, in which the pace of iron loss exceeds ability to replete from oral iron intake.
  - ☐ Patient has a time-limited condition (i.e. perioperative) where oral iron will not provide adequate Hb levels
  - ☐ Other:

- ☐ Other reason why oral iron cannot be used:

Prescriber Information

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A. Overview of AccessLink Service

AccessLink Drug Navigation Services ("**AccessLink**") offered and administered by BioScript is aimed at simplifying access to patient care and medication access through assistance in administrative and drug reimbursement navigation support (the "**Services"**). As part of my participation in the Services, I understand that I will be offered confidential patient support services, at no cost, including but not limited to administrative, drug navigation and reimbursement support and may be contacted by phone, email or otherwise.
Services offered may include:

- Benefits investigations and reimbursement support, including assistance in identifying potential coverage requirements and eligibility for financial support;
- Coordination of required paperwork and forms submission to facilitate coverage for prescribed medications;
- Coordination and enrolment with available patient support programs;
- Coordination of medical services including pharmacy, clinical and other paramedical services; and
- Such other services that AccessLink may offer you

The AccessLink Services do not provide medical advice or medical diagnosis. You agree to seek the advice of your treating physician or other qualified healthcare provider(s) if you have a health concern and not to disregard professional medical advice based on the information obtained from AccessLink. AccessLink reserves the right at any time, without notice, to modify, discontinue or terminate the Services.

You acknowledge that you have read the below Consent terms and you consent to the transfer of your personal information, health information, and the prescription (if applicable) to AccessLink.

B. Consent to Collection, Use and Disclosure of Personal Information

What information: You hereby authorize AccessLink to collect, use and disclose your personal information and health information to provide you the Services, including your:

- Health & Drug Insurance
- Prescription Information
- Drug Interactions
- Adverse Event Information
- Medical Conditions & Medical History
- Medication Shipment & Treatment Dates
- Personal Information (Name, Address, Contact Information)

Who may we interact with: AccessLink may collect, use and disclose your personal information and health information as needed to provide you the Services, including with your healthcare providers (physician, nurse practitioner, pharmacist, etc.), pharmacy of choice, public or private insurance or benefits provider and any Patient Support Program ("PSP") that you are or will be enrolled in. You authorize AccessLink to collect and disclose your personal information and health information to and from the above listed individual(s) and organization(s).

For what purpose: The purpose of the collection, use and disclosure of your personal information and health information is to provide you the Services which may include drug reimbursement assistance, adverse drug event reporting, and to assist your PSP, healthcare providers, and pharmacy of choice to provide their services to you. AccessLink will use your information to provide the Services to you and may also use your information in an aggregate or de-identified form to improve its products and services.
Your personal information and health information collected as part of the Program will be protected by reasonable physical, administrative, and technical safeguards to protect it against loss, theft, and unauthorized access, communication, copying, use or alteration.

How long does this apply? This consent is effective from the day first written above and shall remain effective so long as you receive the Services and for a reasonable period of time thereafter. You may refuse to provide this consent to us or withdraw it at any time. If refuse consent, AccessLink will not be able to provide you with the Services. If you withdraw your consent, AccessLink will no longer be able to provide you with the Services, but such withdrawal will not be retroactive.

Your obligations:

a) You must inform us if you cease to be enrolled in your PSP(s) for any reason or if there are any changes to your treating healthcare providers or pharmacy of choice.
b) Provide us accurate information and updates so we can provide you the Services.

Acknowledgements:

a) I understand that my personal information and health information may leave my province of residence and may be stored or processed outside of Canada. If this is the case, then my information would be subject to the laws of that country where it is stored and may be disclosed to that government under different circumstances than it would in Canada.
b) I understand why I have been asked to provide consent to the disclosure of my personal information and health information, and I am aware of the risks and benefits of consenting or refusing to consent.
c) I may ask any questions about privacy and compliance or exercise my privacy rights by contacting the Privacy Officer by email (privacyofficer@bioscript.ca) or telephone (1-888-734-3814).
d) I understand I may withdraw this consent in writing at any time addressed to AccessLink using the contact information below.

AccessLink Drug Navigation Services

To enroll patients: Submit the completed form to AccessLink via fax at 1-855-278-5182. For assistance: email accesslink@bioscript.ca or phone 1-888-398-0028. Please note messages are checked daily and returned within two business days.