AccessLink
a BioScript Solutions service

Myeloma Maintenance and Supportive Care Pathway

Patient Enrolment Form

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

Complete this form for maintenance therapy and supportive care to be administered at the Coverdale Infusion Clinic in closest proximity to the patient's home address.

Patient Information

First Name: _____ Last Name: _____ DOB (MM/DD/YYYY): _____
Phone: _____ Email: _____ Health Card #: _____
Address: _____ City: _____ Prov: _____ Postal Code: _____
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: _____

Indication and Prescription

Autologous SCT Date: _____

☐ **Single agent Maintenance Treatment**
Cycle: _____ Day: _____ Date: _____
Mitte: _____ days Refills: _____

☐ **Lenalidomide:** See ApoSecure Enrolment Form

☐ **Dual Maintenance Treatment**
Cycle: _____ Day: _____ Date: _____
Mitte: _____ days Refills: _____
☐ **Lenalidomide:** See ApoSecure Enrolment Form
☐ **Daratumumab:** See BioAdvance Enrolment Form

Bloodwork (requisition required)

☐ **CBC** every _____ weeks	☐ **Chemistry and electrolytes** every _____ weeks	☐ **SPEP** every _____ weeks	☐ **Quantitative IG** every _____ weeks	☐ **Other:** _____ every _____ weeks	☐ **All** – Pre-Cycle

Supportive Care – to be initiated on Day 1 of maintenance treatment if not active

Bone Targeted Therapy
☐ Zoledronic acid ____mg IV q28Days
(Adjust dose based on renal function)
Continue until: _____

☐ Denosumab 120mg SC every 28 days
☐ Calcium Carbonate _____mg PO _____
☐ Cholecalciferol 1000 units PO _____

Mitte: _____ days Refills: _____

Thromboprophylaxis
☐ ASA 81mg PO Daily
☐ Apixaban _____ mg PO BID
☐ Rivaroxaban _____ mg PO Daily

Mitte: _____ days Refills: _____

GI Prophylaxis
☐ Pantoprazole _____ mg PO _____
☐ Olanzapine _____ mg PO _____
☐ Metoclopramide _____ mg PO _____
☐ Other: _____

Mitte: _____ days Refills: _____

Antiviral Prophylaxis
☐ Valacyclovir _____ mg PO _____
☐ Acyclovir _____ mg PO BID

Mitte: _____ days Refills: _____

☐ **Post Transplant Reimmunizations to be administered per protocol**
*Please send protocol

☐ **Refer to Patient Empowerment Program**

Additional comments:

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

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): _____

For Pharmacy Use Only:
BioScript has reviewed the prescribed vaccinations with your patient, and they have refused the following: _____
☐ BioScript has uploaded all vaccines information in health portal. Pharmacist Initials: _____

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.