ANSWERS®
PATIENT SUPPORT PROGRAM

PATIENT ENROLMENT FORM

An ANSWERS Program Specialist will call patient within 1 business day once they are enrolled

Once this form is completed, fax it to 1-866-772-1458, or scan and email it to ANSWERS@innomar-strategies.com

SELECT PRESCRIBED TREATMENT:

PrGrastofil® (filgrastim) Pre-Filled Syringe
- ☐ 300 mcg/0.5 mL [02441489]
- ☐ 480 mcg/0.8 mL [02454548]

PrLapelga® (pegfilgrastim) Pre-Filled Syringe
- ☐ 6 mg/0.6 mL [02474565]

PrBambevi® (bevacizumab) solution for injection
- ☐ 100 mg (25 mg/mL) ☐ 400 mg (25 mg/mL)

Start Date (DD/MM/YYYY)

Mitte: **Doses:** _____

Cycles: _____

PHYSICIAN INFORMATION

Name

Cancer Centre

Address

Phone **Fax**

Office Contact **Phone**

Email

PERSON ENROLLING (please check one)

☐ Physician ☐ Nurse
☐ Drug Access Navigator ☐ Pharmacist

ENROLLING HEALTHCARE PROVIDER INFORMATION

Name

Cancer Centre

Address

Phone **Fax**

Office Contact **Phone**

Email

PATIENT INFORMATION

First & Last Name **Date of Birth** (DD/MM/YYYY)

Address

City **Province** **Postal Code**

Home Phone **Preferred Language**

Alternative Contact Name & Phone

Email

Is the patient covered by a private drug insurance plan?
☐ Yes ☐ No ☐ Unsure

Is the patient covered by a public plan?
☐ Yes ☐ No ☐ Unsure

If YES, has an application been submitted to the payer?
☐ Yes ☐ No ☐ Unsure

PHARMACY INFORMATION

Pharmacy Name

Address

Pharmacist Name

Phone **Fax**

PATIENT CONSENT:

☐ Using the contact information I have provided, I consent for the Program Administrator and Program Personnel to contact me for the purposes of enrolment into the Program. I consent to the collection, use and disclosure of my personal information for the purposes of Program registration, administration and monitoring.

☐ I have provided my email address and consent to electronic communications for the purpose of providing the services offered by the ANSWERS Program. I understand I can withdraw my consent to electronic communications at any time.

Patient or Primary Next of Kin Signature **Date** (DD/MM/YYYY)

If unable to obtain written consent from patient or primary next of kin, please document verbal consent

☐ Verbal consent obtained for the a) Program Administrator and Program Personnel to contact patient for the purposes of enrolment into the program, and b) collection, use and disclosure of personal information for the purposes of Program registration, administration and monitoring.

☐ Verbal consent obtained for patient to receive electronic communications for the purpose of providing the services offered by the ANSWERS Program. Patient understands that consent to electronic communications can be withdrawn at any time.

Contact an ANSWERS Program Specialist:
1-866-APO (276)-1664

Visit: www.apoanswers.ca

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