PATIENT ENROLMENT FORM

SELECT PRESCRIBED TREATMENT:

PrGrastofil® (filgrastim) Pre-Filled Syringe

- ☐ 300 mcg/0.5 mL [02441489]
- ☐ 480 mcg/0.8 mL [02454548]

PrLapelga® (pegfilgrastim)

- ☐ 6 mg/0.6 mL Pre-Filled Syringe [02474565]
- ☐ 6 mg/0.6 mL Pre-Filled Autoinjector [02529343]

PrBambevi® (bevacizumab) solution for injection

- ☐ 100 mg/4 mL (25 mg/mL) [02520729]
- ☐ 400 mg/16 mL (25 mg/mL) [02520737]

PrLOQTORZI® (toripalimab) solution for injection

- ☐ 240 mg/6 mL (40 mg/mL) [02562219]

Start Date (DD/MM/YYYY) ______________________

Mitte: **Dose:** ______________________

Frequency: ______________________

Diagnosis: ______________________

PHYSICIAN INFORMATION

Name ______________________

Cancer Centre ______________________

Address ______________________

ENROLLING HEALTHCARE PROVIDER INFORMATION

Name ______________________

Phone ______________________ **Fax** ______________________

Email ______________________

PATIENT INFORMATION

First Name ______________________ **Last Name** ______________________

Date of Birth (DD/MM/YYYY) ______________________

Gender: ☐ Male ☐ Female ☐ Prefer not to specify

Patient Email ______________________ **Cell Phone** ______________________

Address ______________________

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

Preferred Language: ______________________

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

Consent to Leave a Voicemail ☐ Yes ☐ No

Consent to Receive SMS ☐ Yes ☐ No

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

ALTERNATIVE CONTACT INFORMATION

Alternative Contact Name ______________________ **Alternative Contact Phone** ______________________

Relationship to Patient ______________________ **Email** ______________________

PHARMACY INFORMATION

Pharmacy Name ______________________

Address ______________________

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 and for the Program to share my information with service providers.

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 Program Administrator and Program Personnel to contact patient for the purposes of enrolment into the Program.

☐ 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.

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

Contact an ANSWERS Program Specialist:
1-866-APO (276)-1664
Visit: www.apoanswers.ca