Pr Osnuvo™
teriparatide (rDNA origin) injection

ENROLMENT FORM

PATIENT CARE PROGRAM

Fax to **1-833-455-0972** or email **osnuvoavir@iqvia.com**

Questions?
Call us at 1-888-303-8702 | or via email osnuvoavir@iqvia.com

Patient sticker

PATIENT INFORMATION

First and last name: _____

DOB (dd/mm/yyyy): _____

Address: _____

City: _____ **Postal code:** _____ **Prov.:** _____

Sex: ☐ F ☐ M ☐ Other

E-mail: _____

Phone number: _____

Best time to call: ☐ AM ☐ PM ☐ Evening

Leave a voicemail? ☐ Yes ☐ No

Drug insurance plan: ☐ Public ☐ Private

Caregiver information (optional)

Allowing the caregiver to also receive the information sent by the program

First and last name: _____

E-mail: _____

I HAVE READ, UNDERSTOOD AND ACCEPTED THE TERMS AND CONDITIONS ON THE BACK OF THIS FORM

_____
Patient signature

Date of signature (dd/mm/yyyy): _____

MEDICAL INFORMATION

Primary diagnosis information

- ☐ Postmenopausal women at high risk of fracture
- ☐ To increase bone mass in men
- ☐ Glucocorticoid-induced osteoporosis (GIO)

Additional diagnosis information

- ☐ History of osteoporotic fracture
- ☐ T-score below or equal to -2.5
- ☐ Inadequate response to anti-resorptive therapy
- ☐ Intolerance or contraindication to anti-resorptive therapy

PRESCRIBER INFORMATION

First and last name: _____

Address: _____

City: _____ **Postal code:** _____ **Prov.:** _____

Phone number: _____

Fax number: _____

E-mail: _____

☑ I, the attending physician/healthcare provider, attest that the named patient has provided their verbal consent to initiate enrolment.

PRESCRIPTION INFORMATION

If prescription information is not provided below, patient has received written prescription.

℞

☑ **Osnuvo** (teriparatide inj., rDNA origin) 600 mcg/2,4 mL
Direction: 20 mcg as a subcutaneous injection DIE
Qty: 1 cartridge (28 doses) **Refills**: _____ months*

No substitution

☑ **TERROSA Pen** - Only pen to be used with Osnuvo; reusable for the entire treatment duration

☑ **Pen needles - Gauge 29G - 31G, 5mm (maximum 12.7mm)**
Qty: 100 **Refills**: _____

* Maximum lifetime exposure to teriparatide is 24 months. Following cessation of therapy, patient may continue on other osteoporosis therapies.

Link to the Osnuvo Injection Training Video

I authorize STI Technologies Limites to be my designated agent to forward this prescription to the pharmacy chosen by the patient. This prescription represents the original prescription drug order for the patient.

I hereby certify that I am prescribing Osnuvo for this patient in accordance with its intended use, contraindications, warnings and precautions as outlined in the Product Monograph.

_____
Physician signature **License #**

Date of signature (dd/mm/yyyy): _____

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PROGRAM TERMS AND CONDITIONS

The Osnuvo Patient Care Program is a program sponsored by AVIR Pharma Inc., the Program Sponsor, for patient assistance and reimbursement support for the product Osnuvo. This Program and related services are intended for and directed to residents of Canada, who have been prescribed Osnuvo by their physician.

Eligible patients who are enrolled in the Program are offered the opportunity to receive educational materials on the management of their condition and help in investigating reimbursement or eligibility for other financial assistance options. You agree to receive, electronically, communications from STI Technologies Limited ("STI") acting on behalf of AVIR Pharma Inc ("AVIR") containing information and updates relating to your enrolment in the Osnuvo Patient Care Program ("Program"). You understand that you may withdraw your consent to such communications at any time by providing notice to STI at osnuvoavir@iqvia.com. In determining your eligibility, you acknowledge that the Service Provider may need to request proof of family income as per applicable provincial or Program Sponsor criteria.

The Program offers these benefits at no cost to enrolled patients; however, the Program Sponsor reserves the right to change the Program's eligibility criteria, change the scope of the services provided, change the Service Provider (currently STI Technologies Limited), terminate your use of the services and your enrollment in the Program, and/or cancel the Program entirely.

Your personal information provided to the Program, during this initial enrolment and/or during any follow up, through telephone calls or otherwise, may be collected, used, disclosed and stored by the Service Provider of the Program on behalf of the Program Sponsor for the purposes of: (1) enrolling you into the Program and monitoring your eligibility for the Program; (2) administering the Program; (3) investigating insurance coverage or eligibility for coverage and/or other financial assistance options with respect to Osnuvo; and (4) verifying the accuracy and completeness of such Information.

By applying for or enrolling in the Program you hereby consent to the Service Provider collecting and using, for the purposes previously described Information from your prescribing physician, insurance company, pharmacist, caregivers and other healthcare providers and disclosing any Information to these sources and any third-party service providers as the Service Provider considers necessary for the purposes of the Program. You also hereby consent to, authorize and direct each of these sources of information to disclose Information to the Service Provider, again solely for the purposes of the Program.

Further, the Program Sponsor, and its applicable third-party service providers, will receive your personal information in the case of an adverse drug event, or as otherwise required by law, as the Program Sponsor must report to health authorities. Aggregate data containing no personal identifying information may also be provided to the Program Sponsor at any time.

In addition to the above, you understand, accept, and agree that your information may be used or disclosed to any party to the extent such disclosure is required by applicable law, regulation or court order.

That being said, your Information will be retained only for as long as is needed to fulfill the purposes of the Program for which it was collected and in order to comply with applicable laws. Industry standard safeguards will be used to protect the security of the Information that is collected.

WITH RESPECT TO THE CONTENT AND INFORMATION PROVIDED BY THE PROGRAM AND ITS THIRD-PARTY SERVICE PROVIDERS, YOU UNDERSTAND THAT THE CONTENT AND THE SERVICE ARE PROVIDED "AS IS" WITHOUT ANY EXPRESS OR IMPLIED CONDITION OR WARRANTY OF ANY KIND, AND YOUR RELIANCE UPON ANY CONTENT OR SERVICE OBTAINED OR USED BY YOU, IS SOLELY AT YOUR OWN RISK. IN NO EVENT SHALL THE PROGRAM SPONSOR BE LIABLE TO YOU FOR ANY AND ALL DAMAGES INCLUDING DIRECT, COMPENSATORY, INDIRECT, INCIDENTAL, CONSEQUENTIAL, SPECIAL, EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATING TO THE PROGRAM. A copy of the Service Provider's policies and practices regarding personal information, and a copy of the Program Sponsor's full Terms of Use for this Program, shall be made available to you either electronically, by mail, or in person.

In order to proceed, the Service Provider requires your consent. In providing your consent you acknowledge that you have understood what has been stated and that you agree to same. Once your consent has been received, this authorization and direction is valid for as long as you receive Osnuvo treatment, and for a reasonable time period thereafter, or until you revoke your consent. You can revoke your consent at any time by contacting the Service Provider; however, you understand that if you revoke this consent, authorization and direction, you will no longer receive services from the Osnuvo Program.

Please forward this form and a copy of the prescription by fax (1-833-455-0972) or email (osnuvoavir@iqvia.com)

Note for the pharmacist:

List of TERROSA Pen ordering information:

McKesson: 179048
PJC: 755440
Familiprix: 192247
Shoppers Drug Mart: 628103457004
Pharmaplus: 457103

Scan to access the Osnuvo Injection Training Video