Bristol Myers Squibb™
Patient Support Program >
Your patient. Our commitment.

OPDIVO (nivolumab)

Pr YERVOY (ipilimumab)

Pr Opdualag™
nivolumab and relatlimab
for injection

PATIENT SUPPORT PROGRAM FOR IMMUNO-ONCOLOGY (IO) ENROLMENT FORM

Toll-free phone number: **1-877-967-6626** | Fax: **1-800-572-4971** | Email: **opdivo@bayshore.ca**

IMPORTANT INFORMATION ABOUT ENROLMENT

All patients must enroll in the Patient Support Program for Immuno-Oncology to receive program services.
To enroll new patients, please complete steps 1, 2 and 3.

STEP 1: Please complete section 1 – Patient information and patient consent.
Please ensure patient consent has been captured below, as it is required to process this request.

STEP 2: Please be sure to complete **only the section 2 relevant for your requested treatment regimen**.
- **OPDIVO, YERVOY, OR OPDIVO + YERVOY** – page 2
- **OPDUALAG** – page 3

STEP 3: Fax the completed enrolment form to the Patient Support Program for IO at 1-800-572-4971 or email opdivo@bayshore.ca

SECTION 1 – Patient information

*** Indicates a required field**

First name:* **Last name:***

Gender:* ☐ M ☐ F **Date of birth (dd/mm/yyyy):***

Patient weight: _____**kg** _____**lb**

Address:* **City:***

Province:* **Postal code:***

Phone:* **Email:**

Preferred method of contact: ☐ Phone ☐ Email **Best time to contact:** ☐ Morning ☐ Afternoon ☐ Night ☐ Permission to leave a message ☐ Do not leave a message

Please select the services for which this patient is seeking assistance:

☐ Eligibility assessment for patient access program
☐ This patient will be paying for his/her treatment out-of-pocket
☐ Infusion clinic (coordination of infusion in private clinics)
☐ Other: _____
☐ Reimbursement navigation
☐ Financial assistance
☐ Immune-mediated adverse reactions (imAR) follow-up calls

Patient consent

I have read and agree to the terms and conditions of the Program and the privacy statement within this form – Schedule A.

PATIENT CONSENT FOR PROGRAM & SERVICES (REQUIRED)

Patient's signature: _____ Date: (dd/mm/yyyy) _____

☐ Patient provided verbal consent

Date (dd/mm/yyyy): _____

Obtained by: Name: _____ Title: _____

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Complete this section 2 for **OPDIVO, YERVOY, or OPDIVO + YERVOY**.

For **OPDUALAG**, see page 3.

SECTION 2 – For OPDIVO, YERVOY, or OPDIVO + YERVOY, please fill out this page

Please specify the diagnosis:	Disease stage being requested:	Line of therapy being requested:

CLINICAL INFORMATION

Histology: _____

Tumor markers or mutational status: _____

Date of resection (if adjuvant): dd/mm/yyyy _____

PRIOR TREATMENT(S) IF APPLICABLE

Line of therapy	Therapy or treatment regimen	Type/dose	Start date dd/mm/yyyy	End date dd/mm/yyyy	Reason for discontinuation

Prescription Information

Please complete the prescription below and fax to 1-800-572-4971 or email opdivo@bayshore.ca.

OPDIVO (nivolumab)

Please see the OPDIVO Product Monograph at https://www.bms.com/assets/bms/ca/documents/productmonograph/OPDIVO_EN_PM.pdf for recommended dosing.

Requested dosing

Dosage per **OPDIVO** infusion:

_____mg every _____weeks _____ # of repeats

Pr YERVOY (ipilimumab)

Please see the YERVOY Product Monograph at https://www.bms.com/assets/bms/ca/documents/productmonograph/YERVOY_EN_PM.pdf for recommended dosing.

Requested dosing

Dosage per **YERVOY** infusion:

_____mg every _____weeks _____ # of repeats

Physician authorization*

I certify that I am the prescribing physician.

Signature: _____

License #: _____ Date: (dd/mm/yyyy) _____

* Please note that for patients infused in specialty infusion clinics (outside of hospital) and for enrolment into patient access programs, a physician signature is required to use this form as a valid prescription.

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Complete this section 3 for **OPDUALAG**.

For all **OPDIVO, YERVOY, or OPDIVO + YERVOY**, see page 2.

SECTION 3 – For OPDUALAG, please fill out this page

Please specify the diagnosis:	Disease stage being requested:	Line of therapy being requested:

CLINICAL INFORMATION

Eastern Cooperative Oncology Group (ECOG) performance status: ☐ 0 ☐ 1 ☐ 2 ☐ 3

CBC with differential (if available): _____

Histology: _____

BRAF Mutational Status: ☐ Wild-type ☐ Mutated ☐ Unknown ☐ Pending results

Prognostic Markers (e.g., PD-L1 expression): _____

M stage: ☐ M0 ☐ M1a(0) ☐ M1a(1) ☐ M1b(0) ☐ M1b(1) ☐ M1c(0) ☐ M1c(1)
☐ M1d(0) ☐ M1d(1)

PRIOR TREATMENT(S)

Line of therapy	Therapy or treatment regimen	Type/dose	Start date dd/mm/yyyy	End date dd/mm/yyyy	Reason for discontinuation

Prescription Information

Please complete the prescription below and fax to 1-800-572-4971 or email opdivo@bayshore.ca.

PrOpdualag™
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for injection

Please see the OPDUALAG Product Monograph at https://www.bms.com/assets/bms/ca/documents/productmonograph/OPDUALAG_EN_PM.pdf for recommended dosing.

Requested dosing

Dosage per **OPDUALAG** infusion: _____ vials of 240 mg nivolumab and 80 mg relatlimab every ____ weeks

Note: the recommended dose and schedule of OPDUALAG for adult and pediatric patients 12 years of age or older and weighing at least 40 kg is 480 mg of nivolumab and 160 mg of relatlimab (2 vials) every 4 weeks.

Physician authorization*

I certify that I am the prescribing physician.

Signature: _____

License #: _____ Date: (dd/mm/yyyy) _____

* Please note that for patients infused in specialty infusion clinics (outside of hospital) and for enrolment into patient access programs, a physician signature is required to use this form as a valid prescription.

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SECTION 3 – Third-party coverage (if any)

☐ Speak to the patient for complete details of his/her insurance program
☐ This patient has the following third-party private insurance coverage

	Insurer	Name of plan participant	Policy #	Certificate #	Has a prior authorization form been sent?
Principal insurance plan					☐ Y ☐ N
Secondary insurance plan					☐ Y ☐ N

Selected infusion site/location (if applicable): _____ ☐ Speak to patient to determine

SECTION 4 – Prescribing physician information

Physician first name:*		**Physician last name:***
Hospital/clinic name:		**Address:**
City:	**Province:**	**Postal code:**
Phone:*	**Fax:***	**Email:**
Preferred method of contact: ☐ Phone ☐ Email		

SECTION 5 – Primary patient coordinator

(Person responsible for patient services, including: enrolment, reimbursement, and coordination of infusion.)

First name:	**Last name:**
Phone:	**Fax:**
Email:	

SECTION 6 – Primary pharmacy contact (required only if treatment will be administered at your institution)†

First name:	**Last name:**
Phone:	**Fax:**
Email:	
Shipping information (ship to):	

† Some private plans may only agree to fund the treatment if it is delivered outside a hospital.

☐ I authorize the Program Administrator in the context of the Program to be my designated agent to forward the prescription by fax or other mode of delivery to the pharmacy chosen by the above-named patient. This prescription represents the original prescription drug order. The original prescription will not be reused.

NOTE: Please complete section 1 and ensure to have the patient consent.

For more information:

Please consult the OPDIVO Product Monograph at https://www.bms.com/assets/bms/ca/documents/productmonograph/OPDIVO_EN_PM.pdf, the YERVOY Product Monograph at https://www.bms.com/assets/bms/ca/documents/productmonograph/YERVOY_EN_PM.pdf and the OPDUALAG Product Monograph at https://www.bms.com/assets/bms/ca/documents/productmonograph/OPDUALAG_EN_PM.pdf for indications, contraindications, warnings, precautions, adverse reactions, interactions, dosing, and conditions of clinical use.
The Product Monographs are also available by calling us at: 1-866-463-6267.

OPTIONAL PATIENT CONSENTS

Communication by email

☐ By checking the consent to be contacted by email box within this form, I agree that the Administrator may communicate with me through email. I understand that email may not be the most secure means of communication, and as such, the Administrator will not include sensitive health information in any emails used to communicate with me. Such emails may, however, identify me as an individual registered with the Program.

Health outcomes research

☐ Patient consented to collect and use information for health outcomes research as described in Schedule C.

Patient's signature: _____

☐ Patient has provided verbal consent (see above)

Contact person

☐ Consent obtained for the person named below to speak for/be spoken to on the patient's behalf:

First name: _____ Last name: _____

Email: _____ Phone: _____

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SCHEDULE A: Program enrolment and patient privacy consent

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOUR PERSONAL INFORMATION WILL BE COLLECTED, USED, AND/OR SHARED FOR THE PURPOSES OUTLINED BELOW.

About the Patient Support Program

The Patient Support Program (which we will refer to as the "Program") is a customer service program that provides patients like you ("you" or "your" refers to you or your child, as the case may be) who have been prescribed OPDIVO, YERVOY or OPDUALAG with information and treatment support services, including:

- information about OPDIVO, YERVOY or OPDUALAG;
- cost reimbursement services, which may include assistance in reviewing eligibility for and coordinating reimbursement and/or financial assistance with your private insurers or any applicable provincial health plan out-of-pocket costs, compassionate use, and infusions and nursing assistance for OPDIVO, YERVOY or OPDUALAG infusions; and
- treatment administration services such as coordinating delivery of OPDIVO to you and assistance with the administration of OPDIVO, YERVOY or OPDUALAG (collectively we will refer to them as the "Support Services").

Your personal information may be collected, used, or disclosed for the Program purposes outlined above and for related purposes outlined in the Use and disclosure of your personal information section below.

Who is running this Program?

The Program is sponsored by Bristol-Myers Squibb Canada ("BMS") and is administered on behalf of BMS by Bayshore HealthCare Ltd., a third-party company that provides client-focused services and patient support programs (we will refer to Bayshore Healthcare as the "Administrator"). If Bayshore HealthCare Ltd. ceases to be the Administrator, BMS may appoint a replacement Administrator to administer the Program. In such a circumstance, your personal information may be transferred to and used by the replacement Administrator in the manner described on this form, to continue to administer the Program and provide you with Support Services.

Collection of your personal information

The Administrator may collect your personal information directly from you and your authorized representatives (e.g., a substitute decision maker), doctors, nurses, pharmacists, private insurance companies, public payers and any other healthcare provider or payer that may possess the necessary information. Generally, "personal information" refers to:

- your name, address, phone number, email address, date of birth;
- details of your medical condition(s), medical history, medical treatments, and drug prescription information; and
- financial information such as your insurance coverage.

The Administrator will only collect the minimum amount of personal information necessary to administer the Program or provide you with the Support Services.

Use and disclosure of your personal information

The Administrator (and its authorized representatives and agents) may collect, use, and/or share your personal information to:

- administer the Program;
- provide you with the Support Services;
- determine your eligibility for the Program and Support Services, including verifying insurance coverage for OPDIVO, YERVOY or OPDUALAG and/or otherwise arranging for reimbursement for OPDIVO, YERVOY or OPDUALAG;
- personalize the Program and Support Services to your specific circumstances;
- provide you with materials relating to your medication, treatment and the Program;
- contact you to inform you of changes in the Program and Support Services;
- obtain your feedback on the Program and Support Services;
- evaluate and report patient outcome data associated with the administration of OPDIVO, YERVOY or OPDUALAG;
- perform internal evaluation and assessments of the Program and Support Services, including limited market research; and
- undertake safety monitoring, reporting and auditing, and responding to enquiries or issues in relation to medication, or as otherwise may be required by law.

The Administrator may also share your personal information with other health professionals in your circle of care (e.g., your doctor, pharmacist) and your public/private health insurance provider to: enroll you into the Program; administer the Program; to provide you with the Support Services; in relation to your medication, treatment, medical condition or other health-related reasons; or as otherwise may be required for legal or regulatory purposes.

BMS's access or use of your information

The Administrator, in the normal course of administering the Program, will not directly share your personal information with BMS or its service providers; however, the Administrator may share your personal information with BMS or its service providers in limited circumstances, including:

- for safety monitoring and regulatory reporting purposes (e.g., reporting an adverse reaction to Health Canada);
- to transfer your personal information to a new Program administrator; or
- to perform audits of the Program in order to evaluate or improve the Program.

Additionally, BMS may transfer any personal information related to the Program in connection with the sale or transfer of all or a portion of its business or assets or rights in those businesses or assets. Should such a sale or transfer occur, BMS will request that the purchaser use and disclose personal information you have provided through this Program in a manner that is consistent with the purposes disclosed here.

The Administrator may share with BMS de-identified or aggregate data generated from information collected in the course of the Program, which may then be used by BMS for the purposes of:

- developing, evaluating or improving the Program and Support Services (including patient participation and experiences) or the OPDIVO, YERVOY or OPDUALAG treatment approaches and implementation;
- financial administration of the Program or Support Services; or
- conducting clinical or marketing research, including future scientific research, regulatory submissions, and publications.

Protection of your personal information

BMS is legally responsible for protecting any personal information collected from you in connection with the Program in accordance with applicable privacy laws. A copy of the BMS Privacy Policy is available at:

< https://www.bms.com/ca/en/privacy-policy.html >

Storage of your personal information

The Administrator and/or BMS may transfer, store, or process personal information outside Canada. In such circumstances your personal information may be subject to the laws of the foreign country where it is stored, and those other foreign countries may have a different level of legal protection than your country of residence. As a result, in certain circumstances, other foreign governments, courts, law enforcement agencies or regulatory agencies may be entitled to access or collect personal information.

Your personal information will be kept for the duration of your participation in the Program and will thereafter be deleted in accordance with the Administrator's and BMS's document retention policies, subject to legal and regulatory requirements.

Access or correction of your personal information

You may request access to and/or correction of your personal information held by the Administrator by contacting them using the information outlined in the Administrator Contact Information section.

Withdrawal from the Program or withdrawal of consent

Your participation in the Program is voluntary. If you choose not to participate, neither your medical treatment nor your insurance coverage eligibility will be impacted. You may refuse to sign the consent form and/or refuse to consent to the collection, use and disclosure of your personal information, as outlined above. However, if you do not consent to the collection, use, and disclosure of your personal information as described in this form, you will not be able to participate in the Program or receive Support Services.

You may cancel your enrolment or revoke your consent at any time by sending a written and signed request to the Administrator using the information outlined in the Administrator Contact Information section. Your cancellation will take effect upon receipt of the letter by the Administrator. In such situations, no new personal information will be collected from you, but your personal information will be maintained as required for legal and regulatory purposes and BMS may continue to use de-identified or aggregated information as described above.

Administrator Contact Information

If you wish to make inquiries or complaints or have other concerns about the collection, use or information of your personal information as part of the Program or Support Services, about the Administrator's personal information practices, to withdraw your consent, or to request access or correction to your personal information you may contact the Administrator in writing using the following contact information:

Mailing address:
Bayshore HealthCare Ltd. 2101 Hadwen Road, Mississauga, ON L5K 2L3

Fax: 1-800-572-4971

The Administrator may need to confirm your identity or request additional details in order to process your request.

BY SIGNING THIS CONSENT FORM:

- I confirm that I have read, fully understand and consent to the collection, use, and disclosure of my personal information in accordance with the terms outlined in this Patient Privacy Consent Form.
- I understand that I am not required to sign this consent form. If I choose not to consent to the collection, use, and disclosure of my personal information, I will not be able to participate in the Program.
- I understand that participation in the Program is not required for me to have access to OPDIVO, YERVOY or OPDUALAG.
- I give permission for my healthcare professionals, pharmacies, health insurance providers or payers to share my personal information, including information about prescriptions, medical condition(s), health, and financial information, with the Administrator or its agents, so that the Administrator may use the personal information to provide the Support Services and administer the Program as described above.
- I understand that telephone calls between me and employees of the Administrator may be monitored or recorded for quality control or training purposes.
- I recognize that my personal information may be transferred and stored outside of Canada.
- I understand that all information provided to BMS may be shared with its group companies for the purposes outlined in BMS's access or use of your information section.
- I understand that BMS may share my personal information with regulatory authorities such as Health Canada or other government agencies in and outside of Canada in the context of reporting any adverse drug events or as otherwise required by law.
- I acknowledge that unless and until revoked, my consent is valid for the duration of my participation in the Program. I accept that even after I withdraw my consent or after I stop participating in the Program my personal information will be maintained as required for legal and regulatory purposes, and BMS may continue to use de-identified or aggregated information as described in BMS's access or use of your information section.
- I accept that BMS reserves the right to modify, suspend, or terminate the Program or any or all Support Service, or any part thereof, at its sole discretion, including changing third-party service providers. BMS will provide me notice of such changes where required by law.

CONSENT TO BE CONTACTED BY EMAIL

By checking the consent to be contacted by email box within this form, I agree that the Administrator may communicate with me through email. I understand that email may not be the most secure means of communication, and as such, the Administrator will not include sensitive health information in any emails used to communicate with me. Such emails may, however, identify me as an individual registered with the Program.

SCHEDULE B: Consent to collect and use information for health outcomes research

From time to time, the Administrator or BMS may conduct research to help insurers, public health plans and regulators understand whether treatment with a product like OPDIVO, YERVOY or OPDUALAG provides benefits such as improved quality of life relative to the cost of the medication ("Health Outcomes Research").

In order to support Health Outcomes Research, the Administrator, or another third party retained by BMS, may collect: (i) information about the medical condition for which OPDIVO, YERVOY or OPDUALAG has been prescribed to you, including patient outcome information (e.g., diagnostic test results, remission information, lifespan, etc.), and (ii) information about your experiences relating to the use of OPDIVO, YERVOY or OPDUALAG. The Administrator may collect this information directly from you or from your circle of care (e.g., doctors). From time to time, the Administrator may share information collected for Health Outcomes Research purposes with BMS on a de-identified or aggregate basis. BMS may use this de-identified or aggregate information to undertake Health Outcomes Research and share its findings with insurers, public health plans, regulators and other interested third parties.

By signing and checking the consent box within this form:

- I agree to participate in Health Outcomes Research related to OPDIVO, YERVOY or OPDUALAG.
- I understand that my participation is voluntary, and that I may withdraw my consent to participate in Health Outcomes Research at any time by notifying the Administrator using the information outlined in the Administrator Contact Information section above.
- I understand that my eligibility to receive the Support Services is not affected by whether or not I agree to participate in Health Outcomes Research.

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