Physician Information

First Name | Last Name

Hospital / Clinic Name | Room #

Address

City | Province | Postal Code

( ) | ( )

Phone | Fax

☐ Telephone ☐ Fax

Preferred Method of Contact

I hereby consent to the collection of information by the *EGRIFTA Support*™ Program ("the Program"), its use to facilitate the functions and activities of the Program, and the disclosure of information collected to Theratechnologies Inc. and its affiliates and its authorized third party subcontractors, agents and consultant (and their respective employees and consultants), for the purposes of regulatory reporting requirements, program monitoring and evaluation and to the collection, use and disclosure of the information as permitted or required by law. My signature acknowledges that I am the attending physician of this patient

Physician Signature | Date (mm/dd/yyyy)

Clinic/Office Contact Information

First Name | Last Name

( ) | ( )

Phone | Fax

☐ Telephone ☐ Fax

Preferred Method of Contact

Patient Information

Gender ☐ Male ☐ Female

First Name | Last Name

☐ English ☐ French

Date of Birth (mm/dd/yyyy) | Language:

Address

City | Province | Postal Code

( ) | ( )

Phone | Work

( )

Alternative

Permission to leave voicemail? ☐ Yes ☐ No

If yes, leave voicemail on ☐ Home ☐ Work ☐ Alternative

Best Time to Contact ☐Daytime☐ Evening

Patient Treatment Information

Is patient on ART ☐ Yes☐ No

Number of years on ART ____

Diagnosis : ☐ HIV Associated Lipodystrophy

Diabetic ☐ Yes☐ No

Waist circumference : ________ cm

Blood fasting Glucose level: ____mg/dL

CT- Scan ☐ Yes☐ No : ________ cm²

Injection Process Information

☐ Review of Injection process (Available through phone)

Insurance Information

	Primary Plan	Secondary Plan
Certificate #		
Group #		

Pharmacy Information

Preferred/Usual Pharmacy
(Optional)

( )

Pharmacy Phone Number

***EGRIFTA Support*™ Program**
70 Wynford Dr., P.O. Box 383, North York, ON M3C 2S7
Telephone: **1-844-788-1933** Fax: **1-844-788-1934**
EPSP@supportprogram.com

Patient Authorization to Disclose Health Information

I understand that the *EGRIFTA Support*™ Program ("the Program") is a program for patients who have been prescribed *EGRIFTA*™ for the first time. I understand that the Program is sponsored by Theratechnologies Inc. ("Thera") and is administered on behalf of Thera by McKesson Canada Corporation and its authorized Program subcontractors and consultants, and their respective employees and consultants("McKesson Canada"), an independent third party located in Toronto, Ontario, ("Program Administrator"). Thera reserves the right to modify or end the Program at any time or to transfer the administration of the Program to another Program Administrator.

I understand that in order to administer the Program, the Program Administrator may collect Personal Information about me from the physician and healthcare provider identified on page 1 (collectively, the "Healthcare Providers"). Personal Information will include my first name, last name, date of birth, gender, telephone number, fax number, email address, mailing address, insurance information (including my plan group number, policy number and certificate number), prescription information, diagnosis, disease state, and a copy of my medical records related to *EGRIFTA*™ treatment (collectively, "Personal Information"). I hereby authorize my Healthcare Providers to disclose my Personal Information to the Program Administrator, and the Program Administrator to collect this Personal Information from my Healthcare Providers, as reasonably necessary to administer the Program. I further authorize the Program Administrator to:

- Communicate with my health insurer(s) to determine my insurance coverage for *EGRIFTA*™ ;
- Communicate with other drug payers to determine whether there are any other reimbursement options available to me for *EGRIFTA*™ ;
- Communicate with my Healthcare Provider for the purposes of securing insurance coverage for *EGRIFTA*™ prescription;
- Communicate with me directly to provide Program information/updates, answer questions on *EGRIFTA*™ treatment, and or to offer new Program services; and
- Communicate with me directly to support me in taking my *EGRIFTA*™ treatment as prescribed.

In carrying out these activities, the Program Administrator may share my Personal Information with my health insurer(s), if any, and possibly other drug payers. My health insurer(s) and/or other drug payers may respond by disclosing information about me and my insurance coverage or reimbursement options for *EGRIFTA*™ to the Program Administrators, who may share this response with my Healthcare Providers and his/her delegates. The Program Administrator will not disclose my Personal Information to Thera, but may disclose information, in aggregate or de-identified form (my name and any information that identifies me has been removed) with Thera (or its third-party service providers) for regulatory purposes, in order to comply with applicable laws, for the purposes of safety reporting (including the disclosure to an affiliate of Thera or a third-party service provider that is not located in Canada.) In the event that Thera changes Program Administrator, I consent to the transfer of my information by McKesson Canada to the new Program Administrator(s).

Applicable federal and provincial privacy laws require the Program Administrator to protect my privacy by requiring that they use and disclose my Personal Information only for the purposes described above or as required by law. My health information will not be used or disclosed by the Program Administrator for any other purposes unless they first obtain my consent or the information that identifies me directly (such as my name) is first removed. These limitations continue even after this Authorization expires (ends) or I revoke (take back) this Authorization.

My Personal Information will be stored by the Program Administrator in a secure and confidential database located in Canada. Access to the database is restricted to authorized employees of the Program Administrator. I also understand that safeguards are used to protect my Personal Information against unauthorized access, disclosure, copying, use or modification

I have the right to request access to my Personal Information that the Program Administrator has on file, which includes the right to amend that Information if it is not correct and to receive an account of how it has been used and a list of the organizations to whom it has been disclosed.

I understand that to request access, I can contact the Program Administrator in writing at Fax: 1-844-780-1934, Mail: 70 Wynford Drive, P.O Box 383, North York, ON M3C 2S7].

I understand that:

- The purpose of the Program is to explore reimbursement options, to advocate on my behalf in an attempt to secure coverage for my prescribed *EGRIFTA*™ therapy and to support me to start and to continue taking my *EGRIFTA*™ treatment. Enrolment in the Program does not guarantee reimbursement;
- Participation in the Program is not required to access *EGRIFTA*™ therapy;
- I do not have to sign this Authorization, but if I do not, I will not be able to participate in the Program;
- I may revoke (take back) this Authorization at any time by faxing or mailing a signed letter of revocation to the *EGRIFTA Support*™ Program [Fax: 1-844-788-1934 Mail: 70 Wynford Drive, P.O Box 383, North York, ON M3C 2S7], but if I do so, I will no longer participate in the Program;
- Unless and until revoked, this Authorization is valid for as long as I am enrolled in the Program; and
- I am entitled to a copy of this Authorization.

Signature of Patient or Legal Representative/Substitute Decision-maker	Date
Printed Name of Patient or Legal Representative /Substitute Decision-maker	Legal Representative/Substitute Decision-maker Relationship to Patient

EGRIFTA and *EGRIFTA Support* are trademarks of Theratechnologies Inc.

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