UNIK ACCESS PROGRAM

Phone : 1-855-756-7660
Fax : 1-855-756-7661
Email : UnikAccessProgram@innomar-strategies.com

PATIENT ENROLLMENT FORM

PHEBURANE® (TASTE-MASKED GRANULES OF SODIUM PHENYLBUTYRATE)

DIAGNOSIS (PLEASE SPECIFY ENZYME DEFICIENCY): _____

Has the diagnosis been confirmed:

☐ Yes (please specify diagnostic method used) _____ ☐ No (please specify expected date of confirmation) _____

PATIENT INFORMATION:

To be completed by the patient or legal guardian.

_____ _____ DATE OF BIRTH : ____/____/____ GENDER : ☐M ☐F
FIRST NAME LAST NAME DD MM YY

_____
ADDRESS

_____ _____ _____
CITY PROVINCE POSTAL CODE

_____ _____ LEAVE MESSAGES : ☐Yes ☐No PREFERRED TIME TO CALL : ☐AM ☐PM ☐Evening
PREFERRED PHONE NUMBER ALTERNATE PHONE NUMBER

_____ _____
ALTERNATE CONTACT NAME IF APPLICABLE (PARENT/LEGAL GUARDIAN) ALTERNATE CONTACT PHONE NUMBER

_____
EMAIL

PHYSICIAN INFORMATION:

_____ _____
NAME SPECIALTY

_____
ADDRESS

_____ _____ _____
CITY PROVINCE POSTAL CODE

_____ _____ _____
CONTACT PHONE FAX

_____ PREFERRED METHOD OF CONTACT ☐Phone ☐Fax ☐Email
EMAIL

PRESCRIPTION:

☐Pheburane® Granules ☐Pheburane® Solution

TOTAL DAILY DOSE (OF SODIUM PHENYLBUTYRATE): _____ TO BE ADMINISTERED _____ TIMES PER DAY.

DOSE OF SODIUM PHENYLBUTYRATE : _____ MG / KG / DAY OR G / M^2 / DAY (PLEASE CIRCLE WHICH APPLIES)

_____ _____ _____
PHYSICIAN SIGNATURE LICENSE # DATE

PHYSICIAN AUTHORIZATION:

I am prescribing as per my clinical judgement and certify that the use of Pheburane® for this patient is based on my clinical decision-making. I have reviewed the Pheburane® Product Monograph and informed the patient (or their parent or legal guardian) about the potential benefits and risks associated with its use. I consent to be contacted by representatives of Innomar or Medunik about the patient, Pheburane®, the Program, and any product complaints or adverse event experienced by the patient. I consent to the use of my prescribing information for the purposes of administering, monitoring, as well as assessing and demonstrating the effectiveness of the program. Also, I understand that health economic and outcomes based studies may be conducted in the future and I consent to being contacted by representatives of Innomar or Medunik for related information.

_____ _____
SIGNATURE DATE

Please see reverse for Patient Consent and Privacy →

PATIENT CONSENT AND PRIVACY

AGREEMENT TO DISCLOSE HEALTH INFORMATION

Medunik Canada has contracted with Innomar (the "Administrator") to provide the Unik Access Program (the "Program"). As part of my enrolment in the Program, I agree and consent to the following :

- My Health Care Providers, the Administrator and the Unik Access Program personnel ("Program Personnel") may collect, use, disclose amongst each other and store my Health Information for the purposes of determining my eligibility for the Program, conducting Program related activities and delivering Program services to me.
- Program Personnel may contact me and leave messages for me regarding my Health Information or any other information required for the administration of the Program.

I further understand that :

- The Administrator is required to collect, use and store my Health Information at all times in accordance with applicable laws including the Personal Information Protection and Electronic Documents Act and any substantially similar applicable provincial legislation governing the protection of personal information
- Program Personnel will not (i) collect, use, disclose or store my Health Information for any activity other than the activities outlined above, or (ii) disclose my Health Information to anyone other than my Healthcare Providers (including Medunik Canada and its employees), unless the Health Information that identifies me is removed (for example, my name and address)
- Notwithstanding the foregoing, Medunik Canada may, either directly or indirectly through a third party auditor, access Health Information collected by Administrator for quality control purposes or to ensure Administrator's compliance with applicable law
- I may withdraw my consent at any time by mailing or faxing a signed request to the Administrator at the fax number 1-855-756-7661 or to the Administrator at the address below, but if I do so, I understand that to the extent that such consent is necessary to provide the services under the Program, my participation in the Program may be terminated and, among other things, I may not be able to get help with reimbursement for Pheburane®
- Except where prohibited by law, I may obtain a copy of my Health Information and may correct any errors and/or direct any questions regarding the collection, use, disclosure and storage of my Health Information to the Administrator at the address below
- Telephone calls to or from the Administrator in the course of its administration of the Unik Access Program may be monitored or recorded for the mutual protection of me and the Administrator
- My Health Information may be collected, used, disclosed and/or stored outside of my province or territory or country, and that the laws of those countries regarding privacy may be less stringent than the laws of Canada and its provinces
- I am entitled to a copy of this document.

Administrator is Innomar Strategies Inc. located at 3470 Superior Court, Oakville Ontario, Canada, L6L 0C4 and its affiliates.

Health Information includes, without limitation, my personal information (name, address, phone number, date of birth, financial information etc.) and personal health information (medical history, medical condition(s), information relating to my treatment, information relating to my health insurance, etc.).

Health Care Providers includes, without limitation, my doctors, nurses, pharmacists and health insurer(s).

Unik Access Program is the Unik Access Program provided by Medunik Canada for the purpose of assisting patients in obtaining access to Pheburane®.

Unik Access Program personnel include the employees and consultants of the Administrator.

I, the undersigned, hereby confirm that

a) I have read, understand and agree with the terms and conditions of this consent form of the Unik Access Program and

b) I understand, agree and consent with the services offered by the Unik Access Program.

_____ _____

PATIENT/ LEGAL GUARDIAN (PRINT NAME) PATIENT/ LEGAL GUARDIAN (SIGNATURE)

_____

DATE (MM/DD/YY)