MARCAN
PATIENT SUPPORT
PROGRAMS

# MAR-DIMETHYL FUMARATE Enrollment Form

**Not available in Quebec*

## Select Prescribed Treatment

**MAR-DIMETHYL FUMARATE**

- ☐ **120 mg (Pack size 56's) DIN 02502690**
- ☐ **240 mg (Pack size 56's) DIN 02502704**

## Best time of day to contact

- ☐ Morning 8 am – 12 pm
- ☐ Afternoon 12 pm – 5 pm

## Prescribing Physician Information

Physician First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Physician Email _____

Physician Office Phone _____ Physician Office Fax _____

Hospital/Clinic _____

## Enrolling Healthcare Provider Information

First Name _____ Last Name _____

Healthcare Centre _____

Email _____

Office Contact _____ Phone _____

Address _____

City _____ Province _____ Postal Code _____

## Person Enrolling (Please check one)

- ☐ Physician ☐ Nurse ☐ Patient
- ☐ Pharmacist

## Patient Information

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Email _____

Preferred Phone _____ Caregiver Phone _____

D.O.B _____ (DD) _____ (MM) _____ (YYYY)

Gender ☐ Male ☐ Female ☐ Other

- ☐ Please contact Caregiver.
- ☐ I authorize the Program to leave a voicemail message that may contain personal or health information at the listed phone number(s).

Is the patient covered by a drug insurance plan (check all that apply)

- ☐ Private ☐ Public ☐ Unsure

*Questions or concerns? Please contact:*

MARCAN

2 Gurdwara Road, Suite #112,
Ottawa, Ontario, Canada – K2E 1A2
Tel: 1-855-627-2261
E-mail: info@marcanpharma.com
Website: marcanpharma.com
e-Fax: 1-613-777-1025

## Patient Consent

By signing this authorization, I hereby consent to enrol in the Marcan Patient Support Program ("Program"), sponsored by Marcan Pharmaceuticals Inc ("Sponsor") and administered through a third party service provider selected from time to time by Sponsor ("Service Provider"). I acknowledge that in order to enrol in the Program as well as to continue my participation in the Program once enrolled, I and/or my physician must provide certain personal and medical information ("Information") to the Service Provider, which will be collected, used and disclosed solely for the purposes of my participation in the Program and for the delivery of care or support to me under the Program. I acknowledge that the Information provided may be transmitted, stored or processed outside of Canada. As such, the Information may be subject to the laws of foreign jurisdictions, and may be accessible to law enforcement and national security authorities there. In such cases, any third party service providers engaged by the Program have been contractually obligated to appropriately safeguard your information to provide a comparable level of protection. Information in personally identifiable form may be disclosed to: (1) persons whose employment function at the Service Provider relates to the Program and may only be used by such persons on a confidential basis for the purpose of providing Program services and for development of the Program, (2) persons involved in my treatment (e.g., my physician, nurses, pharmacists, Drug Access Navigators etc.). Information may be disclosed in personally identifiable form to the Sponsor for regulatory purposes and to third parties where required by applicable laws, court orders or government regulations. Non-personally identifiable information regarding the Program participation and outcomes may be presented in aggregate form to the Sponsor for its use. I authorize the Program to investigate and determine my full benefit potential on my behalf, or that of my dependant, and to direct third-party plans in which I am eligible for drug benefits to release coverage information related to my policy. I understand that the Program may also request additional supporting documentation, including financial information for the purposes of verifying insurance coverage or to otherwise arrange for financial coverage for my use of the above medication(s). I acknowledge that enrolling in the Program is not a guarantee that I will be fully covered. I further agree to participate in any audit as may reasonably be required by the Program to verify the financial information collected as being accurate and my participation in the Program being valid. I further consent to being contacted by mail, telephone, or email from time to time by Sponsor's authorized agents including Service Provider for the above-noted purposes.

I understand that I can withdraw my consent at any time. I am aware that the Information is required for my participation in the Program and that if I do not consent to the collection, use and disclosure of Information, as outlined above, I cannot be considered for participation in the Program. I understand my participation in the Program including access to the medication and financial support may be terminated at any time by the Sponsor, and I further understand that I may cancel my enrollment and this authorization at any time by mailing a letter to: Marcan Pharmaceuticals Inc, 2 Gurdwara Rd. Unit 112, Ottawa, ON K2E 1A2 or such other address as Sponsor or Service Provider may advise.

My cancellation will be in effect upon receipt of the letter by the Service Provider and any further collection, use and disclosure of my Information (medical, financial and personal) will stop.

- ☐ Using the contact information I have provided, I expressly consent for the Program Service Provider to contact me for the purposes of enrollment into the Program and provision of selected services.
- ☐ I have provided my email address and expressly consent to electronic communications. I understand I can withdraw my consent to electronic communications at any time.
- ☐ I expressly consent for the Program Service Provider to contact my prescribing physician for the purpose of confirming the prescription indication in order to determine eligibility for the Patient Support Program.

Patient or Primary Next of Kin Signature

Date (DD/MM/YYYY)

*Questions or concerns? Please contact:*

**Marcan Pharmaceuticals Inc.**
Tel: 1-855-627-226 e-Fax: 1-613-777-1025 email: info@marcanpharma.com Website: marcanpharma.com