KYE Pharmaceuticals

This Program is Available Exclusively at SRX Health

Fax completed form to:
1-855-CORZYNA /1-855-267-9962

SRX Health Patient Support Phone or Fax at: 1-855-267-9962

PrCORZYNA™ (ranolazine) Bridging Support Program

Patient Enrollment & Medical Order RX Form

Patient Information

Last Name	First Name	
Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female	
Street Number	Street Name	
City/Town	Province	Postal Code
Phone (Home)	Phone (Work)	
Y ☐ Consent to leave message	Y ☐ Consent to leave message	
Phone (Cell)	Email	
Y ☐ Consent to leave message		
Diagnosis		
Allergies		

Physician Information

Physician Last Name	Physician First Name	
Designation	Licence	
Street Number	Street Name	
City/Town	Province	Postal Code
Physician Office	Physician Fax	
Nurse Last Name	Nurse First Name	
Nurse Phone		

Date (dd/mm/yyyy) of RAMQ Patient d'Exception Submission

Medical Order - Rx (to be filled in by prescriber only)

CORZYNA 500 mg tablets Prescription :
Dose: 500 mg BID (1 tablet by mouth twice daily)
☐ Days Supply: 60 days (free trial)

Refills: (after RAMQ Patient d'Exception Approval)
☐ 3 Months ☐ 6 Months ☐ 12 Months

Physician Signature:

X_____

Date: _____

Recommended Dose and Dosage Adjustment

Initiate CORZYNA dosing at 500 mg twice daily and increase to 1000mg twice daily, as needed, based on clinical symptoms.

The maximum recommended daily dose of CORZYNA is 1000mg twice daily.

Dose adjustment may be needed when CORZYNA is taken in combination with certain other drugs (see DRUG INTERACTIONS, Drug-Drug Interactions). Limit the maximum dose of CORZYNA to 500mg twice daily in patients taking moderate CYP 3A4 inhibitors such as diltiazem and verapamil. Use of CORZYNA with strong CYP 3A4 inhibitors is contraindicated. Use of P-gp inhibitors, such as cyclosporine, may increase exposure to CORZYNA (see DRUG INTERACTIONS, Drug-Drug Interactions).

Special Instructions

Authorization

Physician Signature	Date (dd/mm/yyyy)
X	

By signing above, I certify that (1) I am the patient's prescribing physician, (2) the above therapy is medically necessary based on the Canadian product monograph, my independent medical judgment and the patient's informed consent; (3) I have received the patient's (or the patient's Legal Representative) express consent and met any other applicable legal or regulatory requirements such as those imposed under provincial or federal law needed to provide KYE Pharmaceuticals Inc (KYE) or its agent, the Program Administrator SRX Health Solutions Inc, and its employees with the information in this form and any other information relevant to provide the Program's services; (4) I have discussed the Program with the patient who wishes to enroll and has agreed that I share their personal information with the Program Administrator to contact the patient and complete the enrollment process; (5) I appoint the Program Administrator as my agent for the purpose of conveying this prescription to the appropriate dispensing pharmacy, and for the administration of two months of CORZYNA (ranolazine) 500mg tablets at no charge to my patient and any other support services associated with the Program; (6) I accept that my information, including personal information, may be used by KYE or its agent and the Program Administrator for reasons in relation to improving, monitoring and auditing the Program, for commercial purposes, or as otherwise permitted by law; (7) I acknowledge that adverse events may be reported about my patient while participating in the Program and understand that I may be contacted by KYE or its agents and the Program Administrator to provide follow-up information; (8) I understand that my information may be processed and stored outside of Canada and; (9) I state the information contained in this application is complete and accurate to the best of my knowledge.

Patient Consent

By signing this Enrollment and Authorization Form, I authorize my healthcare providers, health plans and any other custodian of my healthcare records to disclose my Personal Information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any information about my prescriptions to KYE Pharmaceuticals Inc. and its representatives, agents, contractors, affiliates (collectively, "KYE") and the Program Administrator SRX Health Solutions Inc, for the Program's administration and services. In addition, I consent to KYE, the Program Administrator or any independent third party acting on behalf of KYE and/or Program Administrator to administer the Program including, but not limited to, specialty pharmacies and provincial drug programs contacting me.

I understand that further information about KYE's information handling practices is set out in KYE's Privacy Policy at www.kyepharma.com. I know that if I have any questions about the terms of this Enrollment and Authorization Form or KYE's Privacy Policy I am to contact the KYE Privacy Officer at privacyofficer@kyepharma.com.

I understand that signing this Enrollment and Authorization Form is voluntary and that it is my right to refuse to sign this Enrollment and Authorization Form. If I decide not to sign this Enrollment and Authorization Form, I will not be eligible to participate in the KYE CORZYNA Bridging Support Program and I cannot receive assistance or support from the Program. I also understand that my enrollment in this Program does not guarantee approval and reimbursement by RAMQ and that only two months of CORYZNA is being dispensed free of charge. I understand that I am entitled to a signed copy of this Enrollment and Authorization Form.

I understand that the Personal Information collected as part of the Program will be protected by reasonable technical and physical administrative safeguards to protect it against loss, theft and unauthorized consultation, communication, copying, use or alteration. I also understand that the file containing my Personal Information will be maintained at the offices of the Program Administrator and that only authorized employees, agents and mandataries of the Program Administrator may have access to my Personal Information where necessary for the purposes described in this Enrollment and Authorization form.

I may request access to or correction of my Personal Information at any time by contacting the Program Administer by phone or fax at 1-855-267-9962.

In the event that KYE appoints a new service provider to replace the Program Administrator, I agree that my Personal Information may be transferred to the new service provider.

In the case of an adverse event, KYE may be legally required to report such an event to Health Canada and may be required to perform monitoring or auditing. In the case of adverse event processing and reporting, KYE, its employees and/or representatives and the Program Administrator may have access, use and report my Personal Information to regulators for drug safety and quality purposes. I understand that I may be contacted for additional information to fulfill these obligations.

The Program Administrator or KYE's agent may de-identify, aggregate (combine with other information) and/or anonymize my Personal Information to conduct analyses for commercial, research and publication purposes or to improve the Program. My Personal Information may be stored or processed outside of Canada, including for adverse event processing and reporting requirements. In this event, KYE ensures that my Personal Information is protected. My Personal Information may be subject to the laws of foreign jurisdiction, with a different level of protection than my country of residence.

I may withdraw my consent to the terms of this Enrollment and Authorization Form at any time by sending a notice in writing to KYE CORZYNA Bridging Support Program, c/o SRX Health Solutions Inc, 122 Edenbridge Drive, Etobicoke, Ontario, M9A 3G4 I understand that withdrawal of my consent will end further uses and disclosures of the Personal Information and will put an end to my enrollment in the KYE CORZYNA Bridging Support Program. No new personal information will be collected. Any withdrawal of consent will not be retroactive and any activities relating to my Personal Information prior to my withdrawal will not be affected and will be maintained during the term of the Program for monitoring, regulatory purposes, de-identified or anonymized data may continue to be used as described herein.

From time to time, the Program Administrator may communicate with me for the purposes of providing information and updates relating to the Program. At any time, I may withdraw my consent to participate in such communications by contacting the Program Administrator by phone or fax at 1-855-267-9962.

I have read and understood the patient consent and agree to the collection, use and disclosure of my Personal Information in accordance with the terms contained herein.

Patient/Legal Guardian Signature	Printed Name of Patient/Legal Representative	Date (dd/mm/yyyy)
X		

Verbal Consent Obtained	Date (dd/mm/yyyy)
☐ Yes	