Haven by sentrex

t. 1 (866) 352-3211 | e. haven@sentrex.com

Haven Urology
Patient Enrollment Form

Fax completed enrollment to: 1 (866) 283-3209

1 Patient Information

Name: (First, Last)

Date of Birth: (dd-mmm-yyyy) Gender: ◯ Female ◯ Male ◯ Other

Medical Record Number: Language: ◯ EN ◯ FR ◯ Other:

Patient Email:

Address: City: Province: Postal Code:

Primary Phone: OK to leave message? ◯ Y ◯ N

Alt. Phone: OK to leave message? ◯ Y ◯ N

Preferred Contact: ◯ Patient ◯ Caregiver Time of Day to Contact:

Caregiver Name: (First, Last)

Caregiver Phone #: OK to leave message? ◯ Y ◯ N Relationship to Patient:

Allergies: ◯ NKA

2 Insurance Information

Public Drug Coverage

Health Card #: Provincial Special Authorization Approval: (see attached) ◯ Y ◯ N

Private Drug Coverage

Private Drug Plan: ◯ Y ◯ N % covered: Private Insurance Provider:

Prior Authorization Submitted? ◯ Y ◯ N Date Submitted: (dd-mmm-yyyy)

Notes:

3 Medical Information

Medical Diagnosis: (prior treatment lines if applicable) ◯ nmPC ◯ mCSPC ◯ mCRPC ◯ Other:

BPMH / Medication List Attached: ◯ Y ◯ N Oncology Pharmacist Patient Follow-up Calls Requested: ◯ Y ◯ N

Previous Lines of Therapy: (if applicable)

Notes:

4 Clinic Information

Clinic Nurse:

Phone: Fax:

Email: Preferred Communication: ◯ Phone ◯ Email ◯ Fax

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5 Prescription (Physician/Pharmacy Use)

Prostate Cancer Injectables

○ Degarelix (Firmagon)
DIR: _____
○ 80mg ○ 240mg Quantity: _____ Repeats: _____

○ Goserelin (Zoladex)
DIR: _____
○ 3.6mg ○ 10.8mg Quantity: _____ Repeats: _____

○ Leuprolide (Lupron)
DIR: _____
○ 3.75mg ○ 7.5mg ○ 11.25mg ○ 22.5mg ○ 30mg
Quantity: _____ Repeats: _____

○ Leuprolide (Zeulide)
DIR: _____
○ 2.75mg ○ 22.5mg
Quantity: _____ Repeats: _____

○ Leuprorelin (Eligard)
DIR: _____
○ 7.5mg ○ 22.5mg ○ 30mg ○ 45mg
Quantity: _____ Repeats: _____

○ Triptorelin (Trelstar)
DIR: _____
○ 3.75mg ○ 11.25mg ○ 22.5mg
Quantity: _____ Repeats: _____

Prostate Cancer Orals

○ Abiraterone ○ Blood Pressure Monitor
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Prednisone ○ Dexamethasone
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Bicalutamide
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Darolutamide (Nubeqa)
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Enzalutamide (Xtandi)
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Erleada (Apalutamide)
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Olaparib (Lynparza)
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Niraparib (Zejula)
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Niraparib + Abiraterone (Akeega)
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

○ Relugolix (Orgovyx)
DIR: _____
Dose: _____ Quantity: _____ Repeats: _____

Incontinence

- ○ Megestrol (Megace)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ OnabotulinumtoxinA (Botox)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Tamsulosin (Flowmax)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Mirabegron (Myrbetriq)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Dutasteride (Avodart)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____

Bone Supports

- ○ Calcium Carbonate
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Alendronate (Fosamax)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Denosumab (Jubbonti)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Denosumab (Wyost)
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Vitamin D
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____

Other Drugs

- ○ Other Drug Name: _____
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Tri-Mix
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____
- ○ Other Drug Name: _____
  DIR: _____
  Dose: _____ Quantity: _____ Repeats: _____

Delivery Location: ○ Clinic ○ Home ○ Other:

Therapy Start Date: (if known)

Next Clinic Visit Date: (if known) (dd-mmm-yyyy)

6 Prescriber Information

Prescriber License #: Date: (dd-mmm-yyyy)

MD Name: (printed)

Physician Address: City: Province: Postal Code:

Haven Program Authorization to Disclose Health Information

Please read and agree to these terms ("Agreement") in order to enrol in the Haven Program (the "Program").

I understand and agree to the following:

The Haven Program is provided by Sentrex Health Solutions Inc. and its subsidiaries and affiliates and their respective subcontractors (collectively, "Sentrex"). Haven offers certain patient support services which may include, as applicable insurance reimbursement assistance and pharmacy services. Sentrex reserves the right to modify or terminate Haven at any time without prior notice.

Sentrex is committed to protecting patient confidentiality and patient health information, including without limitation personal information (name, address, contact details, date of birth, financial information) and health information (medical history and conditions, health insurance) (collectively, "Personal Information") in accordance with all applicable laws, including as such terms are defined in the Personal Information Protection and Electronic Documents Act (Canada)) and the Personal Health Information Protection Act, 2004 (Ontario).

My healthcare provider has prescribed certain medication as identified above ("Product/s") for my use and has referred me to the Program. I have discussed the benefits and risks of use of the Product/s with my healthcare provider, I am not relying on the Program for the provision of any medical advice or diagnoses, and I have decided to start treatment on the Product/s. I would like to enrol in the Program to receive Services in relation to Product/s. By signing below, I acknowledge, understand and agree as follows:

Sentrex will, via the Program and such other questionnaires, interview questions or other information gathering processes, electronic or otherwise, which Sentrex may employ, collect, use, disclose and/or store (collectively, "Use") my Personal Information for the purpose of providing the Services, monitoring the Program, reporting adverse events, improving the program and modifying and improving its products and services more generally, or as may be required by applicable law. My Personal Information may be collected from and/or disclosed to my physicians, nurses, pharmacists, insurance providers and others as may be required to provide the Services. Provided my name and other identifying details are removed, I further consent to the disclosure and sharing of my Personal Information within Sentrex and with third parties and governmental authorities, including by way of general publication; The Program may contact me by telephone or electronic mail using the contact information I have provided above, and I shall be responsible for any resulting telecommunication charges.

By signing this document, I consent to a representative of the Haven by Sentrex program enrolling me into a patient support program that may be managed by a third party provider, whereby my personal and health information may be shared, in an effort to assist with coverage of my prescribed products and or services My insurance provider may disclose to the Program my insurance coverage information, and I consent to the Use by the Program of such information for the purpose of verifying coverage and otherwise arranging for reimbursement for the Product/s.

My participation in this Program is voluntary, and I may withdraw this consent at any time by calling the Program at 1-866-352-3211. I further understand that withdrawal of my consent will end the Use of my Personal Health Information by the Program and will result in termination of my participation in the Program and use of the Services.

I acknowledge that that collection, use, disclosure and storage of my Personal Information, and my consent given herein, are subject to and in accordance with Sentrex's electronic privacy policy, a copy of which has been made available at http://sentrex.com/ (the "Privacy Policy"). I acknowledge having read the Privacy Policy and the above provisions of this enrollment form, and having understood them in their entirety. I further acknowledge that I have been given the following contact information if I have questions regarding the contents of this Consent & Authorization form or the Privacy Policy, or if I wish to withdraw any consent herein in accordance with the Privacy Policy: Sentrex Health Solutions, Attn: Privacy Officer, 120 Valleywood Dr, Markham, ON, L3R 6A7, Email: privacy@sentrex.com

- I asked all the questions about the specifics of my treatment.
- I have given access to my personal information and consent that the pharmacy can communicate with my doctor regarding my health when necessary.
- I give consent to the pharmacy to communicate with my insurer regarding a claim. I was offered the option of using my own pharmacy.
- I freely and fully consent to this prescription being carried out by Sentrex Pharmacy having an administrative agreement with the clinic.

I have read this form, including the Consent, or it has been read to me. I agree to be enroled in the Haven Program and authorize the use and disclosure of my information as described on this form.

Signature of Patient (or Patient's Legal Representative)

Date (dd-mmm-yyyy)

Printed Name of Patient (or Patient's Legal Representative)

Legal Representative's Relationship to Patient

○ **Verbal Consent Obtained**

By Whom

Date (dd-mmm-yyyy)