# XHALE program enrollment and consent form† All sections MUST be completely filled out.

I hereby acknowledge that I am this patient's health care provider. Furthermore, I confirm that the patient has been prescribed PrXOLAIR*. I certify that I have on file an authorization from the patient to disclose and authorize further disclosure of the patient's health and insurance information for the purposes of the XHALE Program ("Program"). I certify that I have provided the patient with information that describes the Program.


***Telephone:***
1-866-9XOLAIR (1-866-996-5247)
***Fax:***
1-866-872-5771


## *Referring physician* *(please print)*

First name _____ Last name _____

License # _____

Specialty _____

Address _____

City _____ Province _____ Postal code _____

Office contact name _____

( _____ ) _____ - _____
Telephone

( _____ ) _____ - _____
Fax

E-mail _____

Would you like to receive post-injection reports?
☐ Yes ☐ No
☐ On request

## *Service options*

Product only (and supplies, if required)
☐ To the physician's office ☐ To the patient

XOLAIR* Clinic (patient's XOLAIR* injections and education session will be coordinated by the Program)

Other services (please contact the XHALE Program for information)

## *Prescription dispensing instructions*

XOLAIR* (omalizumab) for subcutaneous injection, 150 mg vial

**Dosage:**
☐ 150 mg s.c. q 4 weeks ☐ 225 mg s.c. q 2 weeks
☐ 300 mg s.c. q 4 weeks ☐ 300 mg s.c. q 2 weeks ☐ 375 mg s.c. q 2 weeks

**Duration of treatment (required supply):**
☐ Initial 6-month supply ☐ Renewal 6-month supply ☐ 12-month supply
☐ Other (please specify): _____

**Patient history and dosing information:**
**Diagnosis:** Allergic asthma ☐ Moderate ☐ Severe
**Prescription type:** ☐ New start ☐ Continued Tx
**Patient's weight:** _____ ☐ lbs ☐ kg

### *Use and disclosure of personal information*

By signing the consent form, I acknowledge and agree that the foregoing terms found in the enrollment and consent form shall also apply, with all necessary adaptations, to the collection, use and disclosure of personal information related to the patient including information about the patient's insurance, prescriptions, medical condition, and health ("Personal Information") to Novartis Pharmaceuticals Canada Inc., its affiliates and/or its agents ("Novartis"), and that such information may be stored outside of Canada. Novartis shall abide by local privacy laws, however such privacy laws may differ from one country to another. I also acknowledge that adverse events may be reported about the patient during the course of the patient's participation in the Program, and agree to be consulted to provide follow-up information, until such time as I explicitly inform Novartis in writing of my desire not to be consulted. Such adverse event reports may need to be forwarded to regulatory authorities in and outside of Canada.

If a third party will administer or dispense XOLAIR* to the patient, I authorize Novartis and/or its agents to transmit prescribing information to such a party.

**X** _____ _____
**Physician's signature** **Date (mm/dd/yyyy)**

## *Patient information* *(please print)*

First name _____ Last name _____

Date of birth (dd/mm/yy) _____ ☐ Male ☐ Female

( _____ ) _____ - _____ ☐ Home ☐ Work ☐ Mobile
Preferred telephone

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

E-mail _____

Address _____

City _____ Province _____ Postal code _____

Legal guardian name (for minor patient) _____

Relationship to patient _____

( _____ ) _____ - _____
Home telephone

( _____ ) _____ - _____
Work telephone

( _____ ) _____ - _____
Mobile number

Special instructions (other contact telephone numbers, etc.) _____

Preferred language: ☐ English ☐ French

### *Patient consent*

I have been informed about the XHALE Program ("Program") purpose and have been given the opportunity to discuss this Program with my health care provider. I understand that it is my right to refuse to sign this consent form. By signing below I agree to enroll in the Program, managed by Novartis Pharmaceuticals Canada Inc., its affiliates and/or its agents ("Novartis"). I am aware that Novartis adheres to a strict privacy policy. I authorize my health care provider(s) and their staff and my health insurer(s), as applicable, to disclose my personal information including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Novartis for the purposes of the Program and as otherwise permitted or required under law. I also authorize my health care provider to provide Novartis with this completed request form on my behalf so that a Program coordinator can contact me in connection with the Program. I acknowledge that I am responsible for any charges by my cell phone provider should I choose to be contacted on my cell phone for purposes of the Program. My Personal Information will not be used or disclosed for any purpose other than as described above. All information collected will be archived by Novartis to collect unidentifiable aggregate data for study or Program management purposes. I understand that I have the right to revoke this consent at any time by contacting the XHALE Program at 1-866-9XOLAIR (1-866-996-5247), however information about me already collected and disclosed for the purposes of the Program will not be destroyed. Except under those exceptions specified by applicable law, I may arrange a right of access to the information held by Novartis and may rectify deficient information. Novartis reserves the right to terminate the Program at any time without prior notice or delay.

If an adverse event is disclosed by me and/or about my state of health through the Program, this information will be conveyed to Novartis, in addition to my initials (and date of birth and/or gender, if known), so that Novartis can follow-up with my health care provider appropriately. This is necessary for Novartis to maintain the most up to date records as to the safety of its products. Adverse event information collected about me for the purposes of adverse event reporting may be viewed, stored and analyzed outside of Canada. Novartis will abide by the local applicable privacy laws in each country. Adverse event information may also need to be reported to health authorities in and outside of Canada. Novartis may also be required to review my Program data (with my initials only to identify me) in order to confirm the accuracy of the safety data collected through the Program.

☐ I agree to be contacted by Novartis for market research purposes.

**X** _____ _____
**Patient/Legal Guardian signature** **Date (mm/dd/yyyy)**

## *XHALE checklist* Did you include

- IgE level test results — IgE _____ (units)
- Positive skin prick or *in vitro* reactivity allergen test results
- Pulmonary function test results
- Completed and signed patient consent
- Physician signature

† Please complete ALL sections entirely to ensure prompt review and processing.

Xhale

XOLAIR* is indicated for adults and adolescents (12 years of age and above) with moderate to severe persistent asthma who have a positive skin test or *in vitro* reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. XOLAIR* has been shown to significantly decrease the incidence of asthma exacerbations and improve control of asthma symptoms in these patients. Safety and efficacy have not been established in other allergic conditions.

Please see Product Monograph for complete information on warnings, precautions and adverse reactions.