Amicus assist™

ENROLMENT FORM

Tel: 1-833-239-6139 Fax: 1-833-297-8808
Email: AmicusAssistProgram@innomar-strategies.com

1.0 PATIENT INFORMATION

Name (Last, First): ______________________ Gender: ☐ M ☐ F Date of Birth (MM/DD/YY): ______________

Address: ______________________ City: ______________ Province: ________ Postal Code: ____________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Preferred Number: ☐ Home ☐ Work ☐ Cell OK to Leave Message: ☐ Home ☐ Work ☐ Cell

Email: ______________________

Diagnosis: ☐ Fabry Disease ☐ GLA Genotype: ______________________

Current Medications: ______________________

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2.0 PATIENT CONSENT

I, the undersigned, have read the terms and conditions and, I understand and agree with the service offered by the Program and the consent and permission on the **reverse side** of this form.

Signature of Patient or Legal Representative: ______________________ Date (MM/DD/YY): ______________

Printed Name of Patient or Legal Representative: ______________________ Legal Representative Relationship to Patient: ______________

☐ **Yes** ☐ **No** I declare that I am 18 years or older. I consent to the receipt of electronic communications from the Administrator, and Program Personnel, for the purposes of determining my eligibility for the Program, conducting Program-related activities and in the delivery of Program services to me. Email communications may be sent to the address I have provided. I understand I can withdraw my consent at any time.

IMPORTANT: If healthcare provider is unable to obtain written consent from patient, please document when patient verbal consent was obtained. This will allow the program to continue with processing this enrolment. Written consent will be obtained by the program. Verbal consent obtained by healthcare provider.

Name: ______________________ Date (MM/DD/YY): ______________

3.0 PHYSICIAN INFORMATION

Physician Name: ______________________ Specialty: ______________

Address: ______________________ City: ______________ Province: ________ Postal Code: ____________

Telephone: ______________ Fax: ______________ Email: ______________________

Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Preferred Method of Contact: ☐ Telephone ☐ Fax ☐ Email

4.0 PRESCRIPTION

PRODUCT NAME: **PrGALAFOLD® (migalastat HCl) 123 mg hard capsules**

☐ 123 mg (1 capsule) once every other day for 28 days Refill X: ____________

Special Instructions: ______________________

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Physician Signature: ______________________ License No.: ______________ Date (MM/DD/YY): ______________

PrGalafold® (migalastat)

Amicus assist™

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AGREEMENT TO DISCLOSE HEALTH INFORMATION

Fax this form to: 1-833-297-8808

Amicus (the "Manufacturer") has contracted with the Administrator to provide the Amicus Assist™ Program (the "Program"). As part of my enrolment in the Program, I agree and consent to the following:

- My Health Care Providers, the Administrator, the Manufacturer and Amicus Assist 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 and
- Program Personnel may contact 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 Amicus and its employees), unless the Health Information that identifies me is removed (for example, my name and address).
- Notwithstanding the foregoing, Amicus 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 set out above 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 PrGALAFOLD®.
- 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 Amicus Assist 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 and
- I am entitled to a copy of this document.

By signing below, I acknowledge that I have read and understand these terms.

Administrator is Innomar Strategies Inc. located at 3470 Superior Court, Oakville, Ontario, L6L 0C4 and 2600 Alfred-Nobel, Ville Saint-Laurent, QC, H4S 0A9.
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 include, without limitation, my doctors, nurses, pharmacists and health insurer(s).
Amicus Assist Program is the PROGRAM NAME and the personnel provided by Amicus for the purpose of assisting patients in obtaining access to PrGALAFOLD® (Migalastat). **Amicus Assist Program personnel** include the employees and consultants of the Administrator.

It is the express wish of the parties that this consent form and all related documents, including notices and other communications, be drawn up in the English language only.

Signature of Patient or Legal Representative | Date (MM/DD/YY)

Printed Name of Patient or Legal Representative | Legal Representative Relationship to Patient

I declare that I am 18 years or older. I consent to the receipt of electronic communications from the Administrator, and Program Personnel, for the purposes of determining my eligibility for the Program, conducting Program-related activities and in the delivery of Program services to me. Email communications may be sent to the address I have provided.
I understand I can withdraw my consent at any time.

☐ Yes ☐ No

Amicus Therapeutics®