SIVEM HORIZON

PATIENT SUPPORT PROGRAM

ENROLLMENT FORM

The form must be filled out by the pharmacist. Please fax the completed form to 1-855-81SIVEM or send it via email to sivemhorizon@patientassistance.ca. Our specialist will contact the patient within 1 business day to complete program enrollment.

PATIENT INFORMATION

First Name Last Name Date of Birth YYYY-MM-DD

Address City Province Postal Code

Email Phone Number Permission to leave voicemail ☐ Yes ☐ No

Gender ☐ Male ☐ Female ☐ Other Language Preference ☐ English ☐ French Insurance Coverage ☐ Private ☐ Public ☐ Uninsured

CAREGIVER OR LEGAL GUARDIAN INFORMATION

First Name Last Name Phone

ENROLLING HEALTHCARE PROVIDER INFORMATION

☐ Nurse ☐ Physician ☐ Pharmacist First Name Last Name

Pharmacy Address Phone Fax

Office Phone Email

PRESCRIBER INFORMATION

First Name

Last Name

Office Phone

Office Fax

Email

Hospital/Clinic

Address

City Province Postal Code

PRESCRIPTION INFORMATION

Please attach the prescription or have the prescriber fill out this section.

☐ SIVEM Imatinib 100 mg (DIN 2521202)

☐ SIVEM Imatinib 400 mg (DIN 2521210)

Quantity Refills Authorized

Directions

Physician License Number (if applicable)

Healthcare Provider Signature Date (YYYY-MM-DD)

CONSENTS (TO BE FILLED IN BY HEALTHCARE PROVIDER AND PATIENT)

I have read and understood the Services Consent Form attached below, and consent to McKesson Canada Corporation and its affiliates using and disclosing my personal information as described.

☐ I authorize the use and disclosure of my personal information for commercial or market research purposes.

Patient/Legal Guardian Signature

Signatory's Relationship to Patient

Print Patient/Guardian Name

Date

☐ I authorize the use and disclosure of my personal information for commercial or market research purposes.

Healthcare Provider Name

Healthcare Provider Signature

Date

VERBAL CONSENT (FOR HEALTHCARE PROVIDER USE, IF APPLICABLE)

By signing below, I certify that I have received the patient's (or the patient's legal representative) express and informed consent and met any other applicable legal or regulatory requirements such as those imposed under provincial or federal law needed to provide the Sponsor or its agents, the Program Administrator, and its employees with the information described in the Service Consent Form on page 2 and any other information relevant to provide the Program's services.

Healthcare Provider Name Healthcare Provider Signature

SIVEM HORIZON

SERVICES CONSENT FORM

Patient Consent

McKesson Canada Corporation and its affiliates (the "Program Administrator") will process your personal information ("PI") on behalf of Sivem Pharmaceuticals ULC ("Sponsor"). Your PI includes individual information (name, address, phone number, date of birth, etc.), demographics (age and sex), financial information (as it relates to any request under the program), and health information (medical history, medical condition(s), information relating to your treatment, and information relating to your health insurance coverage). Your PI will be collected by the Program Administrator from you or from Sponsor, insurance providers and healthcare professionals. The Program Administrator will collect and process your PI for the purposes of administering the program, communicating with you, auditing or monitoring the program, performing activities as required or permitted by law, such as monitoring product complaints and reporting adverse events, and providing program Services, including: (1) healthcare professionals' support; (2) assistance in communicating with drug plan administrators, managers and insurance companies to aid in securing reimbursement coverage for your prescription; (3) report on your insurance coverage to your healthcare professionals; (4) counselling; and (5) Program Administrator will also use your PI to: (a) combine it with personal information of other patients, or (b) de-identify, aggregate, and/or anonymize it, in each case for data assessments and data analytics, including to better understand and improve the Services, for research purposes aimed at improving healthcare services and outcomes, and to generate reports that may be shared with Sponsor. Your PI will be shared with Program Administrator's employees, agents, consultants and service providers, with healthcare professionals and other third parties, such as insurance providers, and with Sponsor, as needed for the program's administration and services or as required under applicable law. If Sponsor appoints a new program administrator, your Personal Information may be transferred to such program administrator to ensure continuity of program Services. Program Administrator may store or communicate your PI outside of your jurisdiction, provided that this takes place in accordance with applicable law and that your PI receives adequate protection. Your PI will be maintained for as long as the program is in operation and as may be required thereafter to meet legal requirements (e.g., maintaining patient records). You can withdraw your consent at any time, by contacting the Program Administrator in writing using the contact information below, provided you understand that: (A) your participation in the program will come to an end as your PI is required for such participation in the program, and (B) the Program Administrator will retain your PI that it collected prior to your withdrawal of consent, and may continue to be use and disclose your PI (a) as required by law, (b) where it is permitted or required to use or disclose your PI without your consent, (c) as previously described where it is de-identified, aggregated, or anonymized data, or (d) in order to either complete the delivery of an in-progress service to you or to discontinue the in-progress service, subject to your preference. You consent to the foregoing, including for data assessments and data analytics as set forth above. If you wish to make inquiries, request access or correction to your PI, or have other concerns about the privacy practices applicable to the program Services, you may contact Program Administrator in writing at SIVEM Horizon, sivemhorizon@patientassistance.ca.

Health Care Provider Consent

McKesson Canada Corporation and its affiliates (the "Program Administrator") will process information about you, including personal information. The information includes individual information (name, address, phone number, license number, etc.) and information regarding your professional activities as part of the program. Such information will be collected from you, from Sivem Pharmaceuticals ULC ("Sponsor") or other healthcare professionals, as applicable. The Program Administrator will collect and process such information for the purposes of administering the program, communicating with you, auditing or monitoring the program, performing activities as required or permitted by law, such as reporting adverse events, and providing program Services, including: (1) healthcare professionals' support; (2) assistance in communicating with drug plan administrators, managers and insurance companies to aid in securing reimbursement coverage for prescription; (3) report on insurance coverage to healthcare professionals; (4) counselling; and (5) Program Administrator will also use your information to: (a) combine it with personal information of other healthcare providers, or (b) de-identify, aggregate, and/or anonymize it, in each case for data assessments and data analytics, including to better understand and improve the Services, and to generate reports for commercial or market research purposes. Your information will be shared with the Program Administrator's employees, agents, consultants and service providers, and as applicable with third parties, such as insurance providers and healthcare professionals, and with Sponsor, as needed for the program's administration and services or as required under applicable law. If Sponsor appoints a new program administrator, your Personal Information may be transferred to such program administrator to ensure continuity of program Services. To the extent you seek to enroll patients in the Program, you consent to the processing of such information. The Program Administrator may store or communicate information outside of your jurisdiction, provided that this takes place in accordance with applicable law and that such information receives adequate protection. Your information will be maintained for as long as the program is in operation and as may be required thereafter to meet legal requirements. You consent to the foregoing, including for data assessments and data analytics as set forth above. You can withdraw your consent at any time, by contacting the Program Administrator in writing using the contact information below, provided you understand that: (A) Program Administrator will retain your information that is collected prior to your withdrawal of consent, and may continue to use and disclose your information (a) as required by law, (b) where it is permitted or required to use or disclose your information without consent, (c) as previously described where it is de-identified, aggregated, or anonymized data, or (d) in order to either complete the delivery of an in-progress service to a patient or to discontinue the in-progress service. If you wish to make inquiries, request access or correction to your information, or have other concerns about the privacy practices applicable to the program Services, you may contact Program Administrator in writing at SIVEM Horizon, sivemhorizon@patientassistance.ca.