PrCORZYNA® (ranolazine) Patient Support Program

Fax completed form to:

1-877-539-1759

Patient Enrollment & Medical 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 (Cell)

Consent to leave message? ☐ Yes | Consent to leave message? ☐ Yes

Email

Consent to email? ☐ Yes

Preferred Method of Communication? ☐ Phone (Home) ☐ Phone (Cell) ☐ Email

Prescriber and Clinic Information

Physician Last Name | Physician First Name

Street Number | Street Name

City/Town | Province | Postal Code

Phone | Fax

Licence

Nurse Last Name | Nurse First Name

Is patient currently taking CORZYNA®? ☐ Yes ☐ No If yes, what dose?

Has the patient previously taken CORZYNA®? ☐ Yes ☐ No

Does the patient have drug coverage? ☐ Yes ☐ No

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

CORZYNA®

☐ Dose 500 mg BID

☐ Dose 1000 mg BID

Other

Days Supply

Refills

☐ 3 Months ☐ 6 months ☐ 12 months

New uninsured patients qualify for free trial supply of 120 tablets of 500 mg CORZYNA®.

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 1000 mg twice daily.

Physician Signature for Authorization of Medical Order and Program Consent

X

Date (dd/mm/yyyy)

Authorization*

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

X

Verbal Consent Obtained From ☐ Patient ☐ Legal Representative | Legal Representative Name | Relationship

Healthcare Representative Who Obtained Consent

Signature of Healthcare Representative | Date (dd/mm/yyyy)

X

*This signed authorization confirms I have read, understood, and agreed to the consent statement on page 2

To contact the CORZYNA® Patient Support Program call: 1-833-918-8893

 Website: www.kyepharma.com COR-029 11/25

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Physician Consent

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 SHN, 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, this prescription is original, valid, and any prior CORZYNA® prescription may be invalidated, and for the administration of 120 tablets of CORZYNA® (ranolazine) 500 mg 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

I understand that for safety concerns, to ensure the integrity of the Program and results, and for the Program administration and related services (the "Purposes"), certain of my information must be shared with Kye Pharmaceuticals Inc. and its representatives, agents, contractors, affiliates (collectively, "Kye") and the Program Administrator. 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 that is reasonably relevant to the Purposes, 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 and the Program Administrator for SHN. In addition, I consent to Kye, the Program Administrator or any independent third party acting on behalf of Kye and/or the Program Administrator to administer the Program including, but not limited to, specialty pharmacies and provincial drug programs contacting me for the Purposes.

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 privacy officer@kyepharma.com. By signing this form, I acknowledge that I have read and agree to the terms herein, including Kye's Privacy Policy.

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 Patient Support Program and I cannot receive assistance or support from the Program. 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 1-833-918-8893 or fax 1-877-539-1759. In the event that Kye appoints a new program administrator to replace the Program Administrator, the new program administrator becomes the Program Administrator hereunder. I agree that my Personal Information may be transferred to the Program Administrator in furtherance of the Purposes. In the case of an adverse event, Kye may be legally required to report such an event to Health Canada and other regulatory bodies 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 to, 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 anonymize my Personal Information (meaning the information cannot directly or with other information re-identify any individual) 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, [United States] including for adverse event processing and reporting requirements. In this event, Kye uses contractual and other means to protect my Personal Information. My Personal Information may be subject to the laws of foreign jurisdictions, with a different level of protection than my country of residence, including rights by law enforcement and government authorities to access the information.

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 Patient Support Program, c/o SHN. 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 Patient 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 1-833-918-8893 or fax 1-877-539-1759.

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.

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