

Please send the completed form to:

 1-877-978-1971

 1-844-662-7827 **OR**  info@serviersource.ca

PATIENT INFORMATION			PATIENT INSURANCE POLICY		
Patient Name: Gender: Male Female Other Date of Birth (dd/mm/yyyy): Primary Contact #: Voicemail OK: Y N Other Contact #: Voicemail OK: Y N Best time to contact: AM PM Email: Address: City: Province: Postal Code: Preferred Language: EN FR Other:			Select all that apply: <input type="checkbox"/> Public insurance coverage <input type="checkbox"/> Private insurance coverage <input type="checkbox"/> No insurance coverage		
PRESCRIBER INFORMATION					
Prescriber Name: License #: Institution Name: Address: City: Province: Postal Code: Institution Primary Contact: Preferred method of contact: Email Phone Fax Phone: Fax: Email:					

PRESCRIPTION INFORMATION

 VORANIGO[®] (Vorasidenib tablets) 10 and 40 mg strength.

VORANIGO is being prescribed for the treatment of Grade 2^a astrocytoma or oligodendrogloma with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation or isocitrate dehydrogenase-2 (IDH2) mutation in adults and pediatric patients aged 12 years and older following surgical intervention. Treatment with VORANIGO is being prescribed following confirmation of an IDH1 or IDH2 mutation through a validated test.

Dosing: Patients weighing ≥40 kg: Starting dose: 40 mg once daily (OD) orally (1 x 40 mg tablet/ OD) Other: _____

Patients weighing <40 kg: Starting dose: 20 mg OD orally (2 x 10 mg tablets/ OD) Other: _____

Duration: 30 days Other: _____ **Refills:** _____ **Start date:** _____

To be delivered at: Home Clinic Other: _____

PHYSICIAN DECLARATION

I certify that my patient's condition is within the indication mentioned above and as per the VORANIGO Product Monograph.

I hereby confirm that (i) I am the patient's prescribing physician; (ii) I authorize Sentrex to be my designated agent to forward this prescription by fax, or other mode of delivery, to the pharmacy chosen by the above named; (iii) I will prescribe the Voranigo product in accordance with Product monograph and supervise the patient; and (iv) I will report any adverse events to Program Provider within 24 hours of being informed of a suspected event. This prescription represents the original prescription drug order for the patient. The patient's chosen pharmacy is the only intended recipient and there are no others. Subject to patient's consent, I consent that Program Provider or Servier Canada Inc. will collect my aforementioned personal information to communicate with me with regard to the Patient, to assist with the Program and patient's care. I consent to the transfer of my personal information should the Program Provider be changed. I accept that my information, including personal information, may be used by Servier Canada Inc. or its agents for reasons related to improving, monitoring, and auditing its programs, or for commercial or market research purposes, and as otherwise required or permitted by law. I have read the patient consent form and agree to my patient being enrolled in the Servier Source Patient Support Program.

Signature: _____ Date (dd/mm/yyyy): _____

PATIENT DISEASE HISTORY

Date of the patient's first surgery (MM/YYYY): _____	Date of subsequent surgery (if applicable) (MM/YYYY): _____
Details of surgery/extent of resection:	
Biopsy	Subtotal resection (50-95%)
Partial resection (<50%)	Total resection (>95%)
Other: _____	Other: _____
Prior or current other anticancer treatment for IDH mutant glioma: Radiotherapy (RT) Chemotherapy (CT) Both (RT/CT) None	

PATIENT ELIGIBILITY

Please tick the boxes that apply to this patient. Please note that it is your responsibility to ensure that the eligibility criteria are met by the patient.

I confirm that the patient has a validated test result for IDH1 mutation

I confirm that the patient has a validated test result for IDH2 mutation

Oligodendrogloma, IDH1 or IDH2 mutation, Grade 2

Astrocytoma, IDH1 or IDH2 mutation, Grade 2

The patient is NOT pregnant or breastfeeding or the patient is a man or woman taking a non-hormonal contraceptive.

The patient has NOT received prior chemotherapy or radiotherapy for glioma.

I confirm that the patient has had liver function tests carried out as per recommendation, and that if liver transaminase elevations have been observed, appropriate dose reduction or discontinuation of VORANIGO has been made.

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Patient Consent

By signing below, I confirm that I have read this form, including the Program Terms and Conditions, or it has been read to me and I understood them. I agree to be enrolled in the Servier Source Patient Support Program and authorize the use and disclosure of my information as described on page 2 of this form.

Signed by: Patient Legal Representative Signature: _____ Date (dd/mm/yyyy): _____

Verbal Consent Obtained from: Patient Legal Representative

Name of Legal Representative: _____ Relationship to Patient: _____

Verbal Consent Obtained by: _____ Signature: _____ Date (dd/mm/yyyy): _____

Program Terms and Conditions

I confirm that I want to enroll in the Servier Source Patient Support Program ("Program") administered by Sentrex Health Solutions ("Program Provider") and sponsored by Servier Canada Inc. (the "Sponsor"), the manufacturer of VORANIGO. I understand and agree to the following:

- Personal and health-related information about me, including my name, contact details, insurance and financial information, medical history, medical condition[s], information relating to my treatment, information relating to my health insurance, and prescription information (collectively "Personal Health Information"), will be collected by Program Provider from me and/or my healthcare professionals (including my physician, nurse or pharmacist), public and private insurance providers, governmental authorities, and/or other sources who hold information about me relevant to the provision of Program services in accordance with all applicable laws, including in the Personal Information Protection and Electronic Documents Act (Canada) and the relevant Personal Information Protection Acts in my province of residence. The Personal Health Information will be collected to allow my enrollment into the Program and to allow me to receive medical treatments and the services related to the Program and;
- The Program Provider will protect my Personal Health Information using industry standard safeguards and will not store, use or disclose them except for the purposes specified herein or as is permitted or required by law. Only the persons who need to see my Personal Health Information will be allowed to access it. My Personal Health Information will be retained only for the time required to fulfill the purposes of collection and for the period of time required to comply with legal requirements.
- I may request access/correction to my personal information at any time or ask questions about privacy by contacting the Program Provider by phone at 1-877-978-1971 or by email at privacy@sentrrex.com.
- My Personal Information may be processed or stored outside of my province of residence or Canada (including in the United States). This means that it may be subject to different privacy laws than those applicable within my province of residence.
- Program Provider may share my Personal Health Information to Sponsor and to the following categories of third parties to report adverse drug events, to monitor product complaints or to ensure continuity of the Program services, for the purposes of administering the Program or to contact me for research purposes: Affiliates, health authorities, a new Program administrator and a third-party research provider.
- My Personal Health Information may be anonymized and used for the purposes of research, education or for other commercial purposes, including by combining it with other data. In such circumstances my Personal Health Information will not be disclosed or shared in a way that could identify me.
- Participation in the program is voluntary and is not required to access VORANIGO. I may withdraw my consent at any time by emailing or faxing a signed request to the Program Provider at the fax number 1-844-662-7827 or email address info@serviersource.ca. If I do so, I understand that my ability to receive the Program services may be limited and the Program may retain Personal Health Information in order to comply with its legal and regulatory requirements.
- The Program Provider or another appointed third party research provider (on behalf of the Sponsor) may contact me by any means (e.g. phone, text, email, mail, etc.) for the purposes of administering the Program or improving the Program (including quality assurance, research purposes, satisfaction surveys, and real-world-data research and analysis).
- The Sponsor has a legal obligation to report adverse drug events to Health Canada and the Program Provider may disclose my Personal Health Information to Servier Canada Inc. and Health Canada for the purpose of reporting any adverse drug event I experience.
- The Sponsor reserves the right to modify the Program or eligibility requirements or terminate the Program at any time and without advanced notice. I will be notified in writing if there is a change in the Program or the Program Provider.
- I confirm that I am a Canadian citizen or resident and that I currently live in Canada.
- My signature (patient or legal representative) on this form confirms that I have read and understand the above statements, and I agree to the provided terms.

Consult the VORANIGO Product Monograph at servier.ca/en/our-products/ for important information on conditions of clinical use, contraindications, warnings, precautions, adverse reactions, interactions and dosing information. The product monograph is also available by calling 1-800-663-0839.



Visit oncoportfoli.ca/patient-support-program/ or
scan the QR code to download this enrolment form
and learn more about the Servier Source PSP.