

## PATIENT ENROLMENT FORM

An ANSWERS Program Specialist will call patient within 1 business day once they are enrolled

SELECT	PRESCRIBED	TREATM	IENT:		
	<sup>Pr</sup> Grastofil® (filgrastim) Pre-Filled Syringe				
	□ 300 mcg/0.5 mL [02441489] □ 480 mcg/0.8 mL [02454548]				
	_				
	® (pegfilgrastir ).6 mL Pre-Filled				
•	).6 mL Pre-Filled				
_	vi® (bevacizuma	•			
	ig (25 mg/mL)		•		
		_			
Start Date	(DD/MM/YYYY				
Mitte:	Doses:				
	Cycles:				
PHYSICI	AN INFORM	IATION			
Name					
Cancer Ce	entre				
Address					
Phone		F	ax		
Office Co	ntact	F	Phone		
Email					
PERSON	ENROLLING	(PI FASE	CHECK ONE)		
Physici		(I LLASE	Nurse		
-	Access Navigat	or	Pharmacist		
ENIDOLI	INC LIEALTH	CARE DR	OVIDED INFORMATIO	<b>-</b>	
ENROLL	ING HEALIH	CARE PR	OVIDER INFORMATION	)N	
Name					
Cancer Co	entre				
Address					
Addiess					
Phone		Fax			
Office Co	ntact	Phone			
Email					

Once this form is completed, fax it to 1-866-772-1458, or scan and email it to ANSWERS@innomar-strategies.com

## **PATIENT INFORMATION**

Yes	First & Last Name	Date o	Date of Birth (DD/MM/YYYY)	
Alternative Contact Name and Phone  Email  Is the patient covered by a private drug insurance plan?  Yes No Unsure  Is the patient covered by a public plan?  Yes No Unsure  If YES, has an application been submitted to the payer?  Yes No Unsure  If YES, has an application been submitted to the payer?  Yes No Unsure  PHARMACY INFORMATION  Pharmacy Name  Address  Pharmacist Name  Phone Fax  PATIENT CONSENT:  Using the contact information I have provided, I consent for the Program Administrator and Program Personnel to contact me for the purposes of enrolment into the Program.  I have provided my email address and consent to electronic communications for the purpose of providing the services offered by the ANSWERS program. I understand I can withdraw my consent to electronic communications at any time  Patient or Primary Next of Kin Signature Date (DD/MM/YYYY)  If unable to obtain written consent from patient or primary next of kin, please document verbal consent  Verbal consent obtained for the Program Administrator and Program Personnel to contact patient for the purposes of enrollment into the Program.  Verbal consent obtained for patient to receive electronic communications for the purpose of providing the services offered by the ANSWERS program. Patient understands that consent to electronic communications can be withdrawn at any time.	Address			
Alternative Contact Name and Phone  Email  Is the patient covered by a private drug insurance plan?  Yes	City	Province	Postal Code	
Email  Is the patient covered by a private drug insurance plan?  Yes	Home Phone	Prefer	Preferred Language	
Is the patient covered by a private drug insurance plan?  Yes	Alternative Conta	ct Name and Phone		
Yes	Email			
Yes	Is the patient co	vered by a private dru	a insurance plan?	
Yes			3	
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	Contact a	n ANSWERS Program	Specialist:	

Visit: www.apoanswers.ca

