methapharm
Administered by Bayshore Specialty Rx

QUINSAIR
levofloxacin solution for inhalation

Toll-Free Phone 1-877-318-4462
Toll-Free Fax 1-866-417-1945
quinsair@bayshore.ca

Enrollment Form

☐ New Enrollment ☐Renewal

Patient Information

First Name: _____ Last Name: _____
Date of Birth (DD/MM/YYYY):_____/_____/ _____ Gender: ☐ M ☐ F
Address: _____ City: _____
Province: _____ Postal Code: _____
Preferred Phone: _____ Alternate Phone: _____
Consent to leave message: ☐ Yes ☐ No Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening
Email address: _____

Drug Plan Information (For Reimbursement Assistance)

Patient has access to:

☐ Public Coverage (eg: Trillium, ODB, Blue Cross, BC Pharma Care, RAMQ, etc.) Plan Details: _____
☐ Private Coverage (private insurance) Plan Details: _____
☐ This patient will pay out of pocket

Physician / Office Information

Physician Name: _____ Hospital / Clinic: _____
License Number: _____ Address: _____
City: _____ Province: _____
Postal Code: _____ Fax number: _____
Telephone number: _____ Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening
Primary office Contact: _____ Contact Number: _____

Prescription (Physician to complete)

☐ QUINSAIR (levofloxacin solution for inhalation)
240 mg administered by inhalation twice daily (28 days on / 28 days off)

28 Day Supply:_____ Refills: _____

Special Instructions:
_____
_____

Physician signature:_____Date:_____/_____/ _____

Patient Consent

I confirm that I have read and understand the Bayshore patient consent information on page 2, and I agree to enroll in the Quinsair Patient Support Program. I authorize Bayshore to collect, use, disclose and store my Personal Health Information as described on page 2 for Program administration and delivery of services. I understand that participation is voluntary and that I may withdraw my consent by contacting the Program.

Patient / Legal Representative Name: _____
Signature:_____Date:_____/_____/_____
Verbal Consent Obtained: ☐ Yes Date:_____/_____/ _____
Obtained by: _____

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BAYSHORE PATIENT ACKNOWLEDGEMENT AND CONSENT

The Quinsair Patient Support Program (The Program) is funded by Methapharm Specialty Pharmaceuticals (the Sponsor) and administered by Bayshore Specialty Rx Ltd. (Bayshore). The Program provides patient support services that may include reimbursement assistance, pharmacy services, and care coordination related to QUINSAIR. Bayshore reserves the right to modify or terminate the Program at any time without prior notice.

Bayshore is committed to protecting patient confidentiality and personal health information, including personal information such as name, address, contact details, date of birth and financial information, and health information such as medical history, medical conditions and health insurance information (collectively, Personal Health Information), in accordance with applicable laws.

My healthcare provider has prescribed QUINSAIR for my use and has referred me to the Program. I have discussed with my healthcare provider the benefits and risks of treatment. I understand that the Program does not provide medical advice, diagnosis or treatment recommendations, and I will direct clinical questions to my healthcare provider. I wish to enroll in the Program to receive Services related to QUINSAIR.

By signing below, I acknowledge, understand and agree that:

- Bayshore may collect, use, disclose and store my Personal Health Information to provide Services, coordinate care, administer and monitor the Program, report adverse events or product quality complaints where required, and comply with applicable laws.
- My Personal Health Information may be collected from or disclosed to my healthcare providers, nurses, pharmacists, insurers, the Program sponsor (Methapharm Specialty Pharmaceuticals), laboratories, and service providers, as reasonably required for the purposes described above.
- Bayshore may contact me by telephone, voicemail, email, mail or another approved contact method using the information I provided, and I am responsible for any related communication charges.
- My healthcare provider may provide this completed and signed enrolment form and prescription to the Program. Signed enrolment is for confirmation of enrollment into the program, to document consent, and for program delivery.
- My insurer may disclose coverage information to the Program, and Bayshore may use that information to verify coverage and support reimbursement arrangements for QUINSAIR.
- Participation is voluntary. I may withdraw my consent at any time by contacting the Program. Withdrawal will not operate retroactively and may affect Bayshore's ability to provide Services or may result in the end of my participation in the Program.
- I may request access to or correction of my Personal Health Information by contacting the Program or Bayshore's Privacy Officer.

WITHDRAWAL, ACCESS OR PRIVACY QUESTIONS
Contact the Quinsair Patient Support Program or Bayshore Specialty Rx Ltd., 2101 Hadwen Road, Mississauga, ON L5K 2L3.
Bayshore Privacy Officer: 1-800-668-9490 Ext. 77001 | privacyofficer@bayshore.ca

PATIENT / SUBSTITUTE DECISION MAKER SIGNATURE

Printed Name: _____ Relationship, If Applicable: _____
Signature: _____ Date (DD/MM/YYYY):____/____/ _____

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