Patient Assistance Program

Shire Pharma Canada ULC ("Shire") developed the VYVANSE Patient Assistance Program (the "Program") for Canadian patients requiring support by covering for the cost of the medication. The Program is available to all eligible Canadians based in the provinces where VYVANSE is not covered under the local (provincial) public plan.

To enroll, you and your doctor must first complete and submit the application form below to find out if you qualify. It is important to fill out all the requested information to avoid delays in processing your application. We have included a checklist at the bottom of this page to guide you through each step.

In order to be eligible, one must meet all of the following requirements:

1. Have a maximum yearly gross household income as listed in table hereunder:

Number of People in Your Household	Maximum Yearly Gross Household Income[1]
1	$24,000
2	$30,000
3	$37,000
4	$44,000
5 or more	$50,000

2. Reside in a Canadian province where VYVANSE is not covered by the public drug plan: Only patients residing in British Columbia, Prince-Edward Island or Newfoundland, as well as patients over the age of 25 residing in New Brunswick or Nova Scotia are eligible. First Nations People and Inuit are covered by the Non-Insured Health Benefits (NIHB) and are not eligible;
3. Not have private insurance.

The submission of a complete application form does not guarantee enrollment in the VYVANSE Patient Assistance Program. You will receive confirmation of the status of your request by mail (approved/declined) once it will have been processed. Please use the checklist below to make sure your application is complete.

APPLICATION CHECKLIST

DOCTOR

❒ Complete all fields in Section 1 & 2.
❒ Sign and date the application form (no stamps, only original signatures accepted).
❒ Provide patient with valid prescription of VYVANSE.

PATIENT

❒ Fill out your personal information in Section 3.
❒ Fill out your financial information in Section 4.
❒ Read and sign the consent in Section 5.
❒ Attach a copy of the initial Notice of Assessment received from Revenue Canada for the most recent year for all adults in household.

When the form is complete (both checklists above), send us your form by mail.
REMEMBER: incomplete or incorrect information may cause processing delays. Therefore, please ensure that all required information is provided, that it is accurate and that all signatures are included.

Mail: VYVANSE Patient Assistance Program
c/o STI Technologies Limited
38 Solutions Drive
Suite 200
Halifax, NS B3S 0H1

The VYVANSE Patient Assistance Program is entirely managed by STI Technologies Limited. If you have any questions, please contact STI Technologies Limited at 1-855-442-9395.

[1] Based on Statistics Canada; Low income cut-offs (before tax) http://www.statcan.gc.ca/pub/75f0002m/2012002/tbl/tbl02-eng.htm

Patient Assistance Program

SECTIONS 1-2 – TO BE COMPLETED BY PHYSICIAN
(Please print clearly)

SECTION 1 PATIENT INFORMATION

First Name | **Last Name** | **Date of Birth (DD/MM/YYYY)**

TREATMENT DETAILS

Has VYVANSE Patient Assistance Program been requested previously for this patient? ☐ **Yes** ☐ **No**

Disorder to be treated with VYVANSE: _____

VYVANSE® dosages covered by this program:

10 mg Capsules DIN: 02439603 **20 mg Capsules DIN: 02347156** **30 mg Capsules DIN: 02322951**
40 mg Capsules DIN: 02347164 **50 mg Capsules DIN: 02322978** **60 mg Capsules DIN: 02347172**

SECTION 2 PHYSICIAN INFORMATION & CONSENT

First Name | **Last Name**

Address

City | **Province** | **Postal Code**

Telephone | **Fax** | **Licence Number**

PHYSICIAN CONSENT

By signing this document, I consent to the collection, use and disclosure of my personal information by a pharmacist, a claims adjudicator, and the sample provider for accounting and process purposes only by STI Technologies Limited. For more information on privacy, please consult www.smartsti.com/privacy.

I understand that the requested Patient Assistance Program is being made possible by Shire Pharma Canada ULC. The drug provided will only be used according to labeling approved by Health Canada (e.g. approved indication, dose, contraindications, dosing regimen).

This is a request for consideration of access to a therapy for a one-year period in extraordinary circumstances. Shire Pharma Canada ULC reserves the right to terminate this program at any time at its sole discretion.

Physician's Signature **Date**

(Original **signature – No stamps)**

Patient Assistance Program

SECTIONS 3-5 – TO BE COMPLETED BY PATIENT OR PARENT/LEGAL GUARDIAN
(Please print clearly)

SECTION 3 PATIENT PERSONAL INFORMATION

First Name | **Last Name**

❒ Male ❒Female
Gender | **Date of Birth (DD/MM/YYYY)**

Address

City | **Province** | **Postal Code:**

Telephone | **Fax**

Contact Name if other than patient | **Relationship to Patient**

SECTION 4 PATIENT OR PARENT/LEGAL GUARDIAN INFORMATION

Do you have private insurance? ☐YES ☐NO

Are you a person of First Nations or Inuit? ☐YES ☐NO

Number of people in your household: **adults =** _____ **children =** _____

Yearly gross household income (before taxes): **$** _____

You must provide proof of the total yearly gross household income to submit an application for this program. Please provide a copy of the initial Notice of Assessment received from Revenue Canada for the most recent year for each adult in your household as indicated above. This is very important as the initial statement shows the revenue and deductions (see example above).

SECTION 5 PATIENT CONSENT

By signing this document, I consent to the collection, use and disclosure of my, or my child's, personal and/or medical information by a pharmacist, a claims adjudicator, and STI Technologies Limited for accounting and process purposes and in order to determine whether or not I can be eligible for this Patient Assistance Program or if eventually my child may benefit from this program.

This is a request for consideration of access to a therapy for a one-year period in extraordinary circumstances. Shire Pharma Canada ULC reserves the right to terminate this program at any time at its sole discretion.

Patient First Name and Last Name(Print)

Signature of patient or applicant if other than patient | **Date**

*VYVANSE is a registered trade-mark used under licence from Shire LLC