CLEAR FORM

Prescription and Enrolment Form[1]

MINJUVI® (tafasitamab for injection) is indicated in combination with lenalidomide for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (R/R DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma, who are not eligible for autologous stem cell transplant (ASCT).[1]

PrMINJUVI® has been issued conditional marketing authorization pending the results of studies to verify its clinical benefit. Patients should be advised of this conditional marketing authorization.

Please fax this form to **1-84-INCYTE-01** (1-844-629-8301) or email it to **support@incytesolutions.ca**.
For more information, call the Incyte Solutions™ Support Program at **1-84-INCYTE-00** (1-844-629-8300).

MINJUVI® tafasitamab for injection 200 mg/vial | Incyte Solutions™ SUPPORT PROGRAM

Patient information and consent

Last name _____ First name _____ Date of birth (DD/MM/YYYY) Sex ☐ F ☐ M ☐ Other _____

Preferred language ☐ English ☐ French ☐ Other _____ Preferred phone # _____ Alternate phone # _____

Consent to leave voicemail ☐ Yes ☐ No Email _____ Preferred communication ☐ Phone ☐ Email ☐ SMS

By providing my mobile phone number and/or my email address, I agree to receive electronic messages using such coordinates from the Incyte Solutions™ Support Program. I understand that I can withdraw my consent in whole or in part at any time by informing the Program in writing.

By signing this form I agree to and have read and understood the above terms and the Patient Terms and Conditions on the reverse side.

Patient or legal representative signature _____ Date (DD/MM/YYYY) _____

If signed by legal representative, name of legal representative and relationship to the patient _____

Prescribing healthcare professional (HCP) information and authorization

Last name _____ First name _____

Specialty _____ City and province _____

Work phone _____ Fax _____

Email _____ Prefer communication by ☐ Phone ☐ Fax ☐ Email

Clinic primary contact/nurse email (if applicable) _____

Clinic stamp and/or additional information:

Diagnosis and previous treatment(s)[1]

Diagnosis: ☐ R/R DLBCL not otherwise specified, including DLBCL arising from low grade lymphoma (not eligible for ASCT)

Additional information (if available): Reason(s) the patient is not eligible for ASCT (select all that apply): ☐ Age ☐ Refractory to salvage chemotherapy ☐ Comorbidities

☐ Refusal of high dose chemotherapy/ASCT ☐ Other Please specify _____ ☐ Unknown

Prior line(s) of therapy (select all that apply): ☐ First-line Please specify _____

☐ Second-line Please specify _____ ☐ Other Please specify _____ Year of diagnosis _____

Prescription information[1]

MINJUVI® and lenalidomide should be initiated on the same day.

Anticipated treatment starting date (DD/MM/YYYY) _____

MINJUVI® dose: ☐ 12 mg/kg OR ☐ Other _____ **Patient's weight** _____ (kg)

Given as an intravenous infusion. Mitte: 4 weeks. Refill information _____

Select the treatment cycle for this MINJUVI® order: ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Additional comments _____

MINJUVI® dosing schedule*†	Day 1	Day 4	Day 8	Day 15	Day 22
Cycle 1	✓	✓	✓	✓	✓
Cycles 2 and 3	✓		✓	✓	✓
Cycles 4+	✓			✓	

Refer to the MINJUVI® and lenalidomide Product Monographs for more information on recommended doses and dose adjustments.

This prescription represents the original of the prescription drug order. My signature acknowledges that the patient has been prescribed MINJUVI® for the treatment noted above. By signing this form, I have read and agree to the Prescribing HCP Terms and Conditions on the reverse side.

Prescribing HCP signature _____ Prescribing HCP License Number _____ Date (DD/MM/YYYY) _____

☐ Check here if prescribing HCP has obtained verbal consent from the patient to share their information with the Program for contact and enrolment purposes

* Each cycle is 28 days long.

† Patients should self-administer lenalidomide capsules at the recommended starting dose of 25 mg daily on days 1 to 21 of each cycle. After a maximum of 12 cycles, stop treatment with lenalidomide and continue to administer MINJUVI® until disease progression or unacceptable toxicity.

Premedications[1]

Administer premedication 30 minutes to 2 hours prior to MINJUVI® infusion to reduce the risk of infusion-related reactions. If a patient has a Grade 1 to 3 infusion-related reaction, premedication should be administered before every subsequent MINJUVI® infusion. Premedications may include the following (select all that apply and, if this is to be used as a prescription, include drug name, dose, route and frequency of administration):*

☐ Antipyretics _____ ☐ Histamine H1 receptor antagonists _____

☐ Histamine H2 receptor antagonists _____ ☐ Glucocorticosteroids _____

Refer to the MINJUVI® Product Monograph for more information regarding infusion-related reactions.

* For patients who do not experience an infusion-related reaction during the first 3 infusions, premedication is optional for subsequent infusions.

Please consult the Product Monograph at pdf.hres.ca/dpd_pm/00080648.PDF for important information relating to conditions of clinical use, contraindications, warnings, precautions, adverse reactions, interactions, dosing, monitoring and laboratory tests, which have not been discussed in this piece. The Product Monograph is also available by calling 1-833-309-2759 or contacting medinfocanada@incyte.com.

MINJUVI® tafasitamab for injection 200 mg/vial

Patient Terms and Conditions

The Incyte Solutions™ Support Program is sponsored and offered by Incyte Biosciences Canada Corporation ("Incyte") in order to support patients who have been prescribed MINJUVI® (tafasitamab) (the "**Program**"). The Program is administered by Incyte and a third-party service provider retained by Incyte to administer the Program, along with their agents and affiliates (collectively, "**Program Administrators**"). Reference to "you", "your" or "I" in this document refers to you as the patient.

In order to enrol you in the Program, your healthcare professional has provided the Program with certain information about you, as outlined on the Prescription and Enrolment Form including your personal information (name, gender, date of birth, address, telephone number, email) and personal health information (medical and insurance information as it affects your therapy and prescription reimbursement) (collectively, your "**Information**").

The Program will collect, use, disclose and store your Information to provide you with the following services ("**Program Services**"):

- Nursing and/or pharmacists' support including infusion services
- Assessment of eligibility to financial assistance
- Assistance in communicating with drug plan administrators, managers or insurance companies to aid in securing reimbursement coverage for your prescription
- Reporting on your insurance coverage to your prescribing healthcare professional (HCP)
- Regular communications on your therapy and support program offerings, where applicable
- Other services as offered from time to time.

Please note that enrolment in the Program may allow access to your Information and/or Program data by healthcare professionals involved in your treatment. By signing and submitting this form, you are consenting to the collection, use and disclosure of your Information by the Program Administrators for administration of the Program and the provision of Program Services and as required or permitted by law and in accordance with the Program's Privacy Policy, which can be obtained by contacting the Program. You also understand that the Program Administrators may contact you according to Information provided in Section 1 of the first page in connection with administration of the Program and provision of Program Services, and you agree to be contacted now and in the future by the Program Administrators including regarding the Program, your condition and/or your MINJUVI® (tafasitamab) prescription.

In addition, you authorize the Program to obtain further information from your prescribing HCP and health insurance company as deemed necessary to ensure the accuracy and completeness of your Information and to administer the Program, and that such further information may include personal information and/or personal health information.

Use and disclosure of your Information

The Program will keep the Information that you provide confidential and will use it only for the purposes of providing you with Program Services and information about the Program or as otherwise described in this paragraph. From time to time, the Program may need to disclose certain Information to a third party who is involved in delivering Program Services. This may include, for example, a dispensing pharmacist, reimbursement navigator, field nurse service or an insurer. The Program will limit the amount of Information disclosed to only that Information required in order to deliver the Program Services to you. The Program may de-identify your information, including for use in providing data to health authorities to support drug access, for reporting purposes, publication, to conduct commercial analysis, research purposes or to improve the Program. All Information collected and recorded by the Program will be treated and maintained by Program Administrators in compliance with applicable privacy and health privacy legislation. Your Information may be collected, used and disclosed and/or stored outside of your province/territory or country, and the privacy laws of those jurisdictions may be less-stringent than the laws of Canada and/or your home province/territory. Your information will be maintained for as long as you participate in the Program and as may be required thereafter in order to meet legal and regulatory requirements. For more information or to address any additional questions, please contact the Program to speak with the privacy officer. Calls may be monitored and recorded for quality assurance or training purposes. You can withdraw your consent at any time by contacting the Program by phone at 1-84-INCYTE-00 (1-844-629-8300) or by email at support@incytesolutions.ca. If you choose to withdraw consent to the Program, please be aware that you may be ineligible for Program Services, including patient support and reimbursement assistance, from the date of withdrawal.

You understand that any financial assistance provided to you as a result of your enrolment in the Program may be reportable income to public or private payers or government agencies. You understand that you are solely responsible for such reporting as well as for ensuring compliance with accepting any such financial assistance.

If you have any questions, please feel free to contact the Program for more information in writing at 1393 North Service Rd. E., Unit 1, Oakville, ON L6H 1A7, fax 1-84-INCYTE-01 (1-844-629-8301), phone 1-84-INCYTE-00 (1-844-629-8300) or email support@incytesolutions.ca. Incyte reserves the right to change the Program Administrator on written notification to you and you consent to your information being transferred to any new Program Administrator for the purposes of continued administration of the Program. Incyte reserves the right to modify or terminate the Program at any time upon providing you with prior written notice.

Prescribing HCP Terms and Conditions

By signing this form, I acknowledge and agree that: (i) I am the prescribing HCP for this patient and am authorized to prescribe the drug product in my province of practice; (ii) this constitutes an original prescription for MINJUVI® (tafasitamab) for the indication specified in Section 3 of this form and, if applicable, pre-medications, (iii) Incyte may de-identify my personal information for use in providing data to health authorities to support drug access, for reporting purposes, publication, to conduct commercial analysis, research purposes or to improve the Program, (iv) I authorize the Program to send the prescription to the patient's pharmacy of choice on my behalf, (v) I have discussed the Program with the patient and have either had the patient sign the consent form, or I have obtained verbal consent from the patient to share their information with the Program for contact and enrolment purposes, as I have indicated on the first page of this form, and (vi) I understand that my information may be collected by the Program and that Incyte and/or the Program may contact me including for the purposes of administering the Program inquiring about my experience with the Program or to provide assistance relating to the prescribing of MINJUVI® (tafasitamab).

I understand that I may revoke this consent by contacting the Program at the contact information set out below.

Contact us to learn more about Incyte Solutions™!

1-84-INCYTE-00 (1-844-629-8300) **support@incytesolutions.ca** **1-84-INCYTE-01** (1-844-629-8301)

To report a possible adverse event or product complaint related to an Incyte product, contact Incyte Biosciences Canada Medical Information: **medinfocanada@incyte.com** or **1-833-309-2759**.

Reference: 1. MINJUVI® Product Monograph. Incyte Corporation. May 21, 2025.

MEMBER OF INNOVATIVE MEDICINES CANADA

REVIEWED BY PAAB

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