ACLASTA® INFUSION MANAGEMENT SERVICE (AIMS) PATIENT BOOKING FORM

VERSION: APRIL 2014

OFFICE USE ONLY – Patient ID: ☐☐☐☐☐

ALL FIELDS ARE MANDATORY. To minimise treatment delays, please ensure all fields are completed.

By completing and submitting this booking form, your patient will be enrolled with the Aclasta® Infusion Management Service (AIMS). The service provides each registered patient with an infusion. You will receive an annual reminder to review this patient regarding their ongoing management. Novartis has engaged third party vendors to provide this service. This service can only be used for Aclasta® and its approved indications. Only one infusion can be administered per patient per twelve months.

Step 1: Patient details (to be completed by the patient or carer authorised to sign consent on behalf of the patient)

First name: | Last name: | Gender: M F

Mailing address

State: | Postcode:

Date of Birth: DD / MM / YY | Phone Number: ( ) | Alt. contact number: (optional) ( )

As a consumer participating in this activity sponsored by Novartis, I have read and understood the privacy statement overleaf and I agree with it. I understand that information relating to an adverse event with a Novartis product that is identified during this activity will be forwarded to Novartis drug safety department, and possibly to health authorities when required.

I understand that unless I tick the statement directly below, I indicate consent for Novartis' drug safety department to contact my (the patient's) healthcare professional for further information regarding any adverse event identified as part of this activity.

☐ I do not consent for Novartis' drug safety department to contact my (the patient's) healthcare professional for further information regarding any adverse events.

Patient's/authorised carer's signature: Required before mailing

Date / /

Step 2: Prescribing doctor details

First name: | Last name:

Clinic address:

State: | Postcode:

Phone number: ( ) | Fax number: ( )

Step 3: Infusion details

Has this patient had an Aclasta® infusion before?

☐ **Yes** → ☐ **If Yes, I confirm that it has been at least 12 months since the patient received their last Aclasta infusion.**

☐ **No**

Infusion Location:

Aclasta infusions will be performed at a nominated infusion location to be discussed with patient upon booking confirmation.

Step 4: Prescription

Please give the Aclasta prescription to the patient for fulfillment prior to infusion appointment. Please instruct patient to bring Aclasta vial to infusion appointment.

For infusions by AIMS Registered Nurse: I hereby request administration of Aclasta® 5 mg to the above patient as an IV infusion over 15 minutes for each prescription of Aclasta® that I write. In accordance with best practice, all infusion nurses will carry an EpiPen® (adrenaline 300 µg) x 2, Loratadine 10 mg oral and/or hydrocortiscone sodium succinate 100 mg (reconstituted in 2 mL of water for injections). In the rare case that a patient displays an acute reaction in the presence of a nurse, during or after an Aclasta® infusion, I give permission for the nurse to administer these if I am not present. As a healthcare professional participating in this activity sponsored by Novartis, I have read and understood the enclosed privacy statement and I agree with it. I understand that information relating to an adverse event with a Novartis product that is identified during this activity will be forwarded to Novartis drug safety department, and possibly to health authorities when required. I understand that my participation in this activity indicates my consent for Novartis' drug safety department to contact me for further information regarding any adverse event identified as part of this activity. If the activity also involves patients, I acknowledge that I must check with my patient before providing the requested follow-up information. (Please see overleaf for privacy statement) ACL1034 April 2014.CRD2429.

Doctor's signature

Date / /

Step 5: Mailing (stamp not required)

Please mail this form to:
AIMS REPLY PAID 80, PO BOX 80, NORTH RYDE BC, NSW 1670