BAUSCH Health

COMPASSIONATE USE PROGRAM – 1 application per patient

PATIENT INFORMATION			
Mandatory Section	Last Name	First Name	Date of Birth (mm/dd/yy)
	Canadian Resident: Yes ☐ No ☐		
	Total *Household* Gross Monthly Income : $_____ (For assessment, CURRENT income in $ (exact, not range) must be provided)	Number of people living in the home *(Household)*: _____	
	Do you have either government or private drug coverage?	Yes ☐ No ☐	
	Comments: If you have drug coverage, why are requesting compassionate use?		

I certify that the information in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage. I understand that Bausch Health, Canada Inc. reserves the right at any time and without notice to modify the application form or modify or discontinue this Program and its related eligibility criteria. I understand that Bausch Health, Canada Inc. reserves the right to recall the product if and when necessary. I understand that I am expected to seek any available government assistance before reapplying to the Bausch Health, Canada Inc. Program. Protection of Personal Information: In providing the Program, Bausch Health, Canada Inc. will comply with all applicable federal and provincial privacy legislation. Your personal information will be used, disclosed and retained for the sole fulfillment of the Program's objectives. Personal information will be kept in strict confidence and will be solely used for the purposes of the Program. Your personal information will only be accessible to Bausch Health, Canada Inc. authorized employees who are directly involved in the administration of the Program. You are entitled to access your personal information and, where appropriate, correct same as provided by law. You may also request that we discontinue maintenance and use of your personal information for the permitted purposes. Such a request, however, will terminate your participation in the Program. Patient's Consent: I understand that the personal information provided by myself and by my physician is provided for the purpose of assessing my eligibility to the Bausch Health, Canada Inc. Program and the potential administration of my file. I acknowledge that I have read and understand this Application Form including the Protection of Personal Information Section, the Program Eligibility, and Instructions enclosed and that I have given my full consent and approval to participate under the conditions described.

_____ _____

Patient's or Legal Guardian's Signature mandatory *Date*

PHYSICIAN INFORMATION			
Mandatory Section	Last Name	First Name	License No.
	CIVIC Address (Carrier cannot deliver to PO Box)	City	
	Province	Postal Code	
	Telephone No:	Fax No:	E-mail address:
	Product requested: ***Note: Maximum to be provided is 3 months Tx***		
	Dosage – (attach prescription):		
	Is the drug listed on provincial formulary	Yes ☐ (Explain reasons for this request in comments section below) No ☐	
	Comments or additional information to support this request, including the names Provide specific information on alternative therapies covered by the public insurance (need to be used before requesting compassionate)		

Please report any adverse event to Bausch Health Canada Inc. by e-mail at medinfo_canada@bauschhealth.com or by phone at 1-800-361-4261.

I, the Licensed Practitioner, represent that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the prescribed medication and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that Bausch Health, Canada Inc. reserves the right to modify or terminate this Program at any time. My signature certifies that products received from Bausch Health, Canada Inc. are for a maximum of 3 months use of the above named patient only within the Health Canada approved indication, and will be provided to the patient on a monthly basis only. These products will not be resold nor offered for sale, trade or barter and will not be returned for credit by myself. I understand that Bausch Health, Canada Inc. reserves the right to recall the product if and when necessary.

Please note: The application and the prescription are to be sent by e-mail at canada.customerservice@bauschhealth.com or by fax to 1-800-361-4266**

_____ _____

Physician's Signature (mandatory) *Date*