PATIENT CONSENT AND PRIVACY NOTE FORM

Acino Pharma (Pty) Ltd incorporating the Litha Pharma Group ("Acino") continually searches for innovative ways to obtain and provide unsurpassed support to patients and Healthcare Professionals. As part of this continued innovation, Acino has engaged Nurse Educators and Administrators to assist patients and Healthcare Professionals by liaising with your Medical Aid and/or a courier pharmacy or clinic on your behalf to ensure you receive and take your prescribed medication timeously for optimal treatment benefits. This is in scope of the Acino Patient Support Programme including Product Reimbursement Assistance ("Programme").

To assist you in deciding whether to participate in the Programme or not, please take your time and carefully read the contents of this Consent Form below, together with the linked Privacy Note on the Processing of Personal Information and if you are in agreement, then please complete and sign the Consent Form below. This Privacy Note describes how Acino collects and uses your personal information which you may provide to Acino for the Programme, upon signing this Consent Form. Acino will not use nor process your personal information unless you have voluntarily and freely signed this Consent Form.

I, _____ ("Patient") or where the Patient is a minor or mentally incapacitated, the Patient's lawful guardian, hereby voluntarily consent to the disclosure of my Personal Information by Dr/Prof _____ ("HCP") to Acino for the sole purpose of my participation in the Programme ("Purpose").

For the purpose of this Consent, Personal Information (including Special Personal Information) shall mean the Patient's name and surname, Identity Number, Age, Gender, Contact details, Address, Physical or Mental health, well-being, disability, Clinical information and the Patient's medical record relating to the disease and any other health-related information that is necessary for the scope of the Programme and reflected in this Consent.

I confirm that I have been provided with and understand the Privacy Note which provides a more complete description on the use, processing and disclosure of my Personal Information.

Having read this Consent Form and the attached Privacy Note and understanding that I can contact medinfo_za@acino.swiss should I need further clarity on or wish to withdraw this consent, including my participation in the Programme, at any time, I, accordingly, hereby freely and voluntarily give my consent to participate in the Programme and for Acino to process my Personal Information for the Purpose as described above.

Patient's/ Guardian's Signature: _____ Date: _____

UNDERTAKING BY ACINO

Acino warrants and undertakes that it has the skill to conduct the Programme for the benefit of ensuring optimal treatment for the patient and will, at all times, use its best endeavours to use, process and keep the Patient's Confidential/Personal Information confidential in accordance with the provisions of the Protection of Personal Information Act No.4 of 2013 and shall use/process such information only for the Purpose in this Consent.

Name: _____ Date: _____

Signature: _____

QR Code to Privacy Note:

MonoFer® CosmoFer® | MOTIVATION

PRESCRIBING PRACTITIONER

Name & Surname			
Name of Facility			
Speciality		Fax	
Address		Tel	
		Email	
		Practice No.	

INFUSION FACILITY

Name of Facility	Paarl Infusion Centre		
Address	Room 8, Paarl Medical Centre Berlyn Street, Paarl, 7646		
Tel	+27 (21) 872 3026		
Email	info@paarlinfusioncenter.co.za		
Practice No.	280 3860		
Hospital PR No.		Treatment Date	

PATIENT DETAILS

Name		Physical Address			
Surname		Initials			
Date of birth		M		F	
ID Number		Email Address			
Medical Aid		Treatment Date			
Membership No.		Hospital Pr No.			
Body Weight		Gestational Age			

PRESCRIPTION

	Monofer®		**CosmoFer®**
	NAPPI 722193001 (Monofer 1000 mg / 10 ml vial)		**NAPPI** 713080001 (Cosmofer 500 mg / 10 ml)
	NAPPI 722192001 (Monofer 500 mg / 5 ml vial)		**NAPPI** 711596002 (Cosmofer 100 mg / 2 ml)

Kindly approve reimbursement for the following indication/s for CosmoFer® or Monofer®

PRIOR TREATMENT INCLUDING ORAL

Medication: _____ Dosage: _____ Duration: _____

CLINICAL DIAGNOSIS

ICD 10 CODES

	D 50.8	Other iron deficiency anaemias		D 50.9	Iron deficiency anaemia - unspecified
	N 18.0 - N 18.9	End stage renal failure		E 61.1	Pure iron deficiency
	D 63.8	Anaemia in other chronic diseases, classifies elsewhere		Other	
	O 99.0	Anaemia complicating pregnancy, childbirth and the puerperium			

Procedure Codes **0201** ☐ **0206** ☐ **5783** ☐

Dr's Signature: _____ Date: _____

IMPORTANT: Please Attach Copies of Latest HB & Iron Studies (not more than 3 months old)

Email to: auth_za@acino.swiss Tel: 087 742 1892