Akynzeo
netupitant 300 mg/
palonosetron 0.5 mg capsule

Knight

AKYNZEO PATIENT SUPPORT PROGRAM (ASSISTANCE)

Assistance is provided on a case-by-case basis; there is no implied commitment to continue providing product on an extended basis to any individual patient. Product supplied under this program is not to be used for sale, resale, trade, barter, or credit return. Billing public or private insurers for product supplied under this program is prohibited.

Refer to the AKYNZEO product monograph for the indication and complete this form and fax to **514-484-4831** or email to **medinfo@knighttx.com** along with the prescription.

REQUIRED INFORMATION

1. INDICATE THE QUANTITY OF BOTTLES:

☒ Akynzeo® *Netupitant 300 mg /palonosetron 0.5 mg per capsule*

QTY: ☐

Maximum is 6 boxes per patient per request. 1 box provide one capsule for one treatment.

2. REASON FOR AKYNZEO USE

☐ Prevention of CINV ☐ Other:____

3. PRESCRIBER NAME ___________________________ **PRESCRIBER EMAIL** _____________________________

4. DELIVERY INFORMATION: Please indicate the medical office or pharmacy address

Clinic/Pharmacy Name____

Address ____

City, Province, Postal Code ____

Upon delivery please notify: ☐ Patient ☐ Healthcare provider (HCP)

Patient Name __________________________

Special delivery instructions ______________

5. Please consent to the following:

☐ I certify that, to the best of my knowledge and after due inquiry, the patient for whom this product is requested has limited financial means and does not have prescription drug coverage through public or private insurance or other programs.

☐ I am a licensed health care professional eligible and authorized to prescribe or dispense these units.

☐ I consent that the personal information provided in this form, necessary to provide the patient with the support program, will be collected, processed and stored in Knight's database, located in Canada and will only be accessed by Knight's employees on a need to know basis. Knight will take appropriate measures to keep this information confidential, in accordance with applicable laws and regulations. I recognize that I can access or rectify my personal information and I can withdraw my consent at any time.

☐ Patient has provided verbal consent that the above information will be shared with all parties involved in dispensing the product and been provided with clear instructions how to opt out of the program at any time.

HCP receiving consent:______________________________Date:______________________

Signature: ____ **Date:**__________________________________

For questions related to Knight products, please contact Medical Information at medinfo@knighttx.com or 1-844-483-5636

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