Bristol Myers Squibb™

Patient Support Program >

Your patient. Our commitment.

The Patient Support Program for REBLOZYL®

Supporting you and your patients throughout the REBLOZYL treatment journey

Visit REBLOZYL.ca to download the PSP resources mentioned on this slide deck

1-833-951-2482

1-833-951-2483

2007-CA-2300010E

Contents

For use on an unsolicited reactive basis only. Programs described in this deck are subject to modification and/or cancellation, at any time, at BMS discretion.

Patient Support Program for REBLOZYL

Designed to support your patients prescribed REBLOZYL (luspatercept for injection) for

ß-thalassemia

- In the treatment of adult patients with red blood cell (RBC) transfusion-dependent anemia associated with beta(ß)-thalassemia

MDS with ring sideroblasts

- In the treatment of adult patients with transfusion-dependent anemia requiring at least two RBC units over 8 weeks resulting from very low- to intermediate-risk myelodysplastic syndromes (MDS) who have ring sideroblasts and who have failed or are not suitable for erythropoietin-based therapy

The Program is not intended to provide medical advice or diagnosis. No costs are involved with Program enrolment.

Services for your patients

Welcome call
Your patient will receive a welcome call from the Patient Support Program for REBLOZYL within 1 business day after the completed enrolment form has been received. During this call, the dedicated case nurse manager will introduce the services of the Program and confirm any required information.

Education tools and support
Education tools and materials for REBLOZYL will be provided to help patients learn more about their treatment and help facilitate discussions during appointments.

Reimbursement navigation (when applicable)
When applicable, reimbursement investigation will be conducted for private and public plans.* Co-pay assistance can be provided to help eligible patients with associated costs for treatment.†

Patient support
The Program will be available from 8 A.M. to 8 P.M. ET to address any patient questions or concerns regarding treatment.

Supply and delivery
Each patient will have a tailored distribution system and will have access to the Program's injection services.‡

Contact the Patient Support Program for REBLOZYL

1-833-951-2482
(for questions or concerns)

1-833-951-2483
(to submit the completed enrolment form)

* A complete investigation and Special Authorization may be required for private coverage plans.
† The Program will contribute co-pay based on each patient's insurance coverage.
‡ Tailored distribution system applies to private clinics only. This involves identifying the closest clinic to the patient's home to administer treatment.

The Program journey

Supporting you in the care of your patients by:

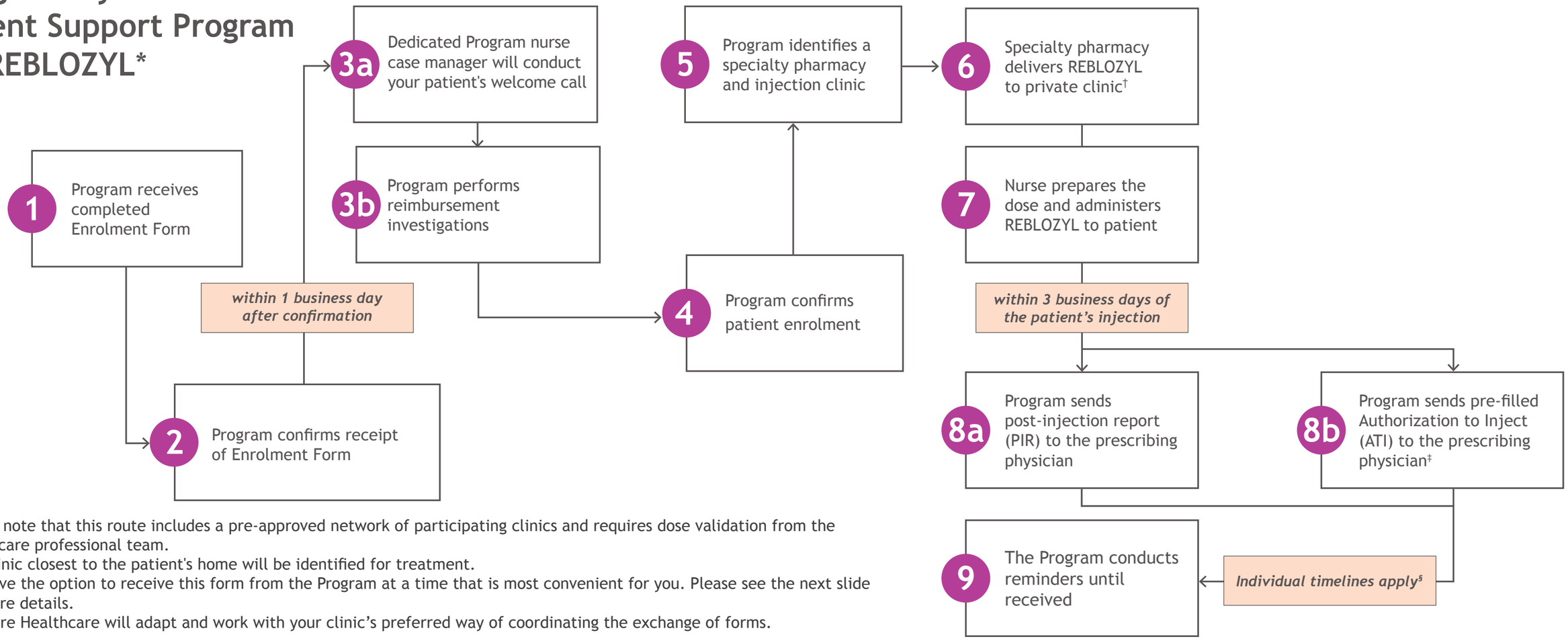
1. **Confirming patient enrolment.** Patients will also receive a welcome call from the Program 1 business day after the Program receives the completed enrolment form.

2. **Conducting reimbursement navigation** (when applicable) to explore coverage options (public and private plans) for your patients. The Program will also provide an update for your patient's coverage options.

3. **Facilitating REBLOZYL at your preferred clinic location.** The Program will help facilitate supply and delivery of REBLOZYL for Injection to the participating clinic as per discussions with your patient.

For private clinics

The journey with the Patient Support Program for REBLOZYL*



* Please note that this route includes a pre-approved network of participating clinics and requires dose validation from the healthcare professional team.
† The clinic closest to the patient's home will be identified for treatment.
‡ You have the option to receive this form from the Program at a time that is most convenient for you. Please see the next slide for more details.
§ Bayshore Healthcare will adapt and work with your clinic's preferred way of coordinating the exchange of forms.

Documentation process for private clinics

Once

At enrolment

ENROLMENT FORM

- Complete the form and all required fields
- **The dosage indicated on this form will be valid for up to 8 dosing cycles (24 weeks)**, unless otherwise specified
- Includes a prescription for first dose, and a checkbox to confirm that Risk Minimization Tools were received

Every 3 weeks

After each injection

POST-INJECTION REPORT

- This form will be completed by the Program and sent to the prescribing physician's clinic **after** each injection

Every 24 weeks (8 dosing cycles) or upon a change of dose

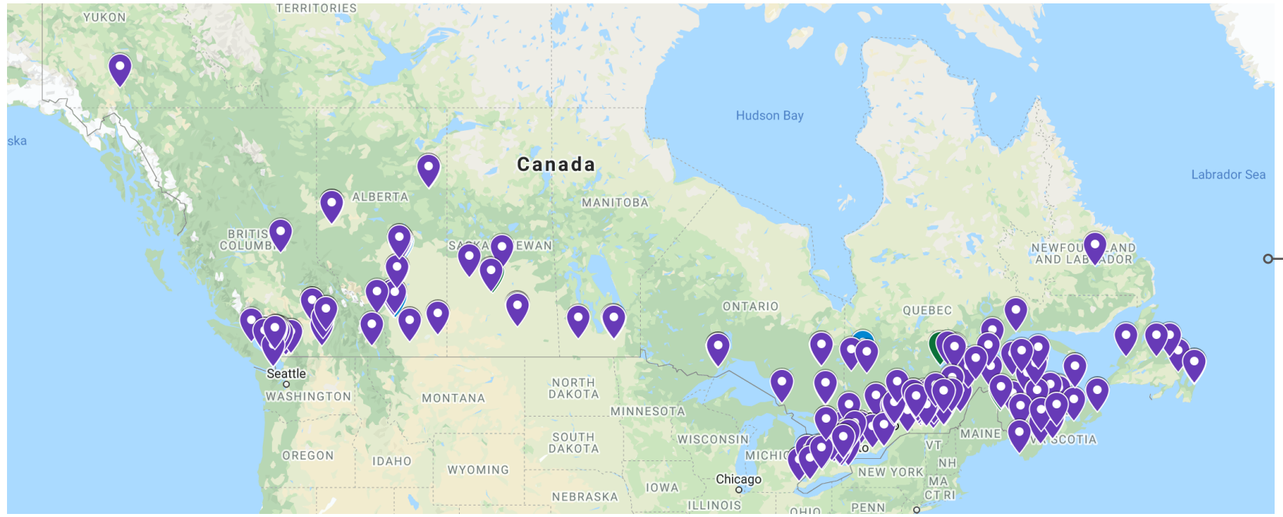
AUTHORIZATION TO INJECT

- This form should be completed **ONLY** in one of the following scenarios:
  - After a period of 8 dosing cycles (24 weeks)
  - Upon a change of dose
  - According to your preference indicated in the Enrolment form*
- The Program will alert you when this 24-week period is coming to an end, and will send you a pre-filled form for renewal†
- The completed form **MUST** be sent back to the Program at least 3 business days prior to the next injection

* Healthcare professionals may opt to receive the Authorization to Inject form more frequently by completing Section 3 (*Clinical information and Prescription*) of the Enrolment form.
† Prior to the next renewal period, the Program will notify the patient's Primary Contact indicated in Section 2 (*Prescribing Physician Information*) of the Enrolment form.

Expanding the availability of REBLOZYL to patients across Canada

In partnership with the Bayshore Clinic Network and sub-contracted clinics



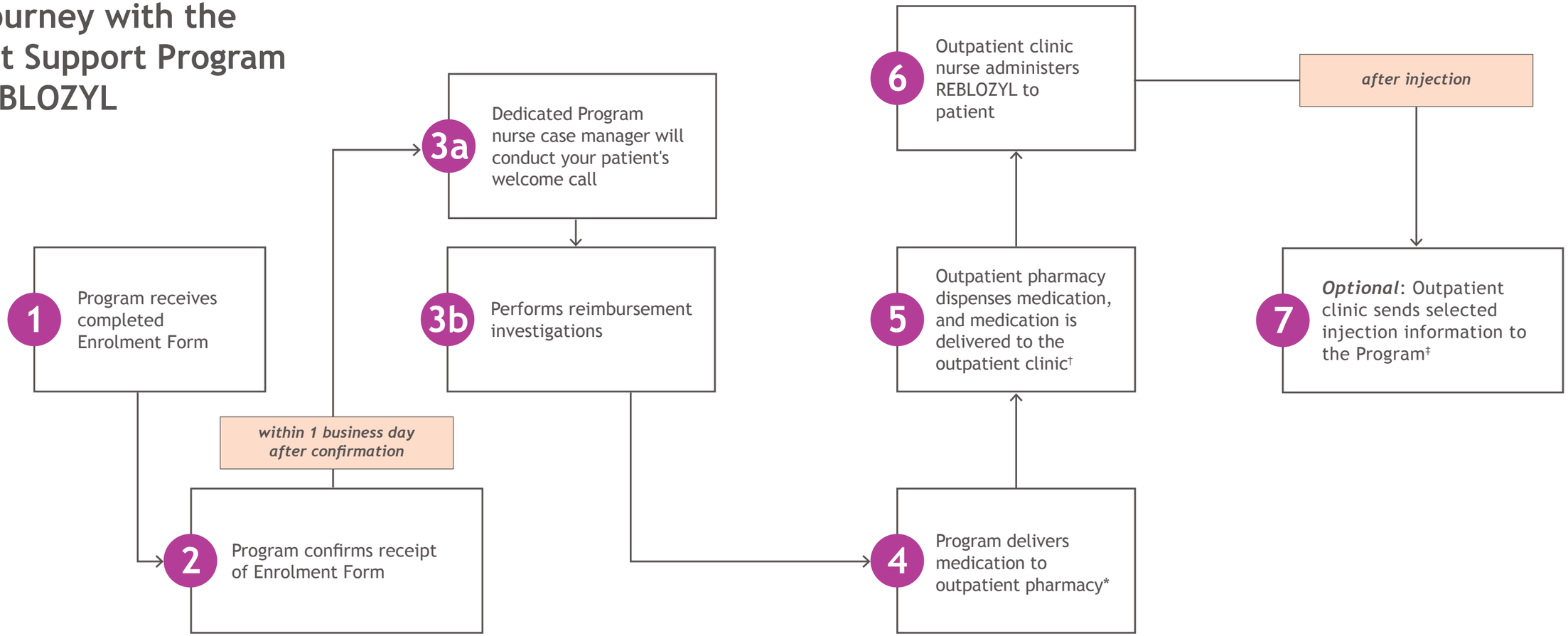
REBLOZYL is available across Canada through the Patient Support Program and through Bayshore Healthcare.

- Bayshore Clinics
- Innomar Clinics™
- INVIVA Clinics
- Clinique de soins spécialisés de l'Est du Québec (CSSEQ)*

*Sub-contracted clinics associated with the distribution of REBLOZYL in Canada.

For outpatient clinics

The journey with the Patient Support Program for REBLOZYL



*Please note that facilitation at this clinic location may require training and additional materials, such as a biofridge.
† Procedures can vary.
‡ After each injection, outpatient clinics may opt to send the date of injection, the date of next injection, and any change of dose for next injection to reblozyl@bayshore.ca.

Documentation process for outpatient pharmacies and outpatient clinics

Once

At enrolment

ENROLMENT FORM

- Complete the form and all required fields
- **The dosage indicated on this form will be valid for up to 8 dosing cycles (24 weeks)**, unless otherwise specified
- Includes a prescription for first dose, and a checkbox to confirm that Risk Minimization Tools were received

Every 3 weeks

***Optional*: After each injection**

To best support you, please consider sending the following information to reblozyl@bayshore.ca after your patient's injection:

1. **Date of the injection**
2. **Date of the next injection**
3. **If there are any changes to your patient's dose (for the next injection)**

The enrolment process

Enrol your patients in 3 steps

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Patient Support Program >

ENROLMENT FORM

Reblozyl®
luspatercept for injection

FAX THIS COMPLETED FORM TO 1-833-951-2483; TO SPEAK WITH A PROGRAM REPRESENTATIVE, CALL 1-833-951-2482 (TOLL FREE), MONDAY TO FRIDAY (8 A.M. – 8 P.M. ET)

Fields denoted by an asterisk (*) are mandatory.

Section 1: Patient Information

Last name*: | First name*:
Date of birth (DD/MONTH/YYYY)*: | Gender: ☐ Male ☐ Female
Address*: | City/Province*: | Postal code*:
Primary telephone number*: | Secondary telephone number: | Email:
Preferred method of contact: ☐ Phone ☐ Email | Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening ☐ Do not leave message
Alternate contact name: | Alternate telephone number:

Third-party coverage*

☐ Speak to the patient for complete details of his/her insurance program ☐ This patient has the following third-party private insurance coverage:

	Insurer	Name of plan participant	Policy #	Certificate #	Has prior authorization form been sent?
Principal insurance plan					☐ Yes ☐ No
Secondary insurance plan					☐ Yes ☐ No

Section 2: Prescribing Physician Information

Last name*: | First name*:
Address*: | City/Province*: | Postal code*:
Telephone number*: | Fax number*: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax
Primary contact name (if different from the prescribing physician):
Telephone number*: | Fax number: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Section 3: Clinical Information and Prescription*

REBLOZYL (luspatercept) is available in 2 vial strengths (25 mg and 75 mg)

☐ Adult patient with transfusion-dependent anemia requiring at least two RBC units over 8 weeks resulting from very low- to intermediate-risk myelodysplastic syndromes (MDS) who has ring sideroblasts and who has failed or is not suitable for erythropoietin-based therapy.

Transfusion-dependent anemia requiring RBC units of
☐ 2-3 units within 8 weeks ☐ 4-5 units within 8 weeks ☐ ≥ 6 units within 8 weeks

Ring sideroblast percentage
☐ ≥ 5% with SF3B1 mutation ☐ ≥ 15%

IPSS-R prognostic risk score
☐ Very low-risk (≤ 1.5) ☐ Low-risk (> 1.5 – 3) ☐ Intermediate-risk (> 3 – 4.5)

ESA treatment history
☐ Failed prior erythropoietin-based therapy ☐ Not suitable for erythropoietin-based therapy

Dosage strength requested

Recommended starting dose†:
☐ 1.0 mg/kg every 3 weeks by SC injection

Dose valid for a maximum of 8 dosing cycles

Otherwise, please specify:

Targeted therapy start date: .....
Patient weight: ..... kg
Date weight taken (DD/MONTH/YYYY): .....

The Authorization to Inject (ATI) form is used when your patient is receiving their REBLOZYL injections. The Program will send you this form at your convenience. Please indicate your preference:
☐ **OPTION 1:** Send me **ONLY ONE** ATI form to complete every 8 cycles. ☐ **OPTION 2:** Send me an ATI form to complete **BEFORE EACH INJECTION.**

Preferred injection clinic* ☐ Private clinic affiliated with the PSP for REBLOZYL ☐ Prescriber clinic, please specify:

Monitor blood pressure and assess and review hemoglobin (Hgb) results prior to each administration. If an RBC transfusion occurred prior to dosing, the pre-transfusion Hgb must be considered for dosing purposes. Please see the Product Monograph for complete dosing recommendations.

By signing below, I acknowledge that I am responsible for informing the Patient Support Program for REBLOZYL of any changes to the prescribed REBLOZYL dosing regimen appropriate for this patient after reviewing and assessing the patient's blood tests prior to each injection. In the absence of any reported changes from Physician to Program, such as adjusting the patient dose or discontinuing treatment based on how the patient responds to REBLOZYL, the Program should continue to dose the patient in accordance with my most recent instructions.

I certify that I am the prescribing physician

☐ I confirm I have received the following REBLOZYL Risk Minimization tools to support my patient during treatment†: Prescriber's Checklist and Patient Card.*

Signature*: | Date (DD/MONTH/YYYY)*:
Physician license number*:

ESA: Erythropoiesis-stimulating agent; IPSS-R: International Prognostic Scoring System, revised; RBC: Red blood cell; SC: Subcutaneous injection.
† If there is an increase in Hgb > 20 g/L within 3 weeks of the previous dose, and in the absence of transfusion, reduce dose as per the dosage adjustment recommendations from the Product Monograph. ‡ Copies of the REBLOZYL Risk Minimization tools can be obtained by contacting Bristol Myers Squibb Canada Medical Information by phone (1-866-463-6267) or by email (medical.canada@bms.com).

STEP 1

Complete the enrolment form (print/digital) with any additional forms required. Ensure written or verbal consent is obtained from your patient

STEP 2

Fax the completed form to 1-833-951-2483

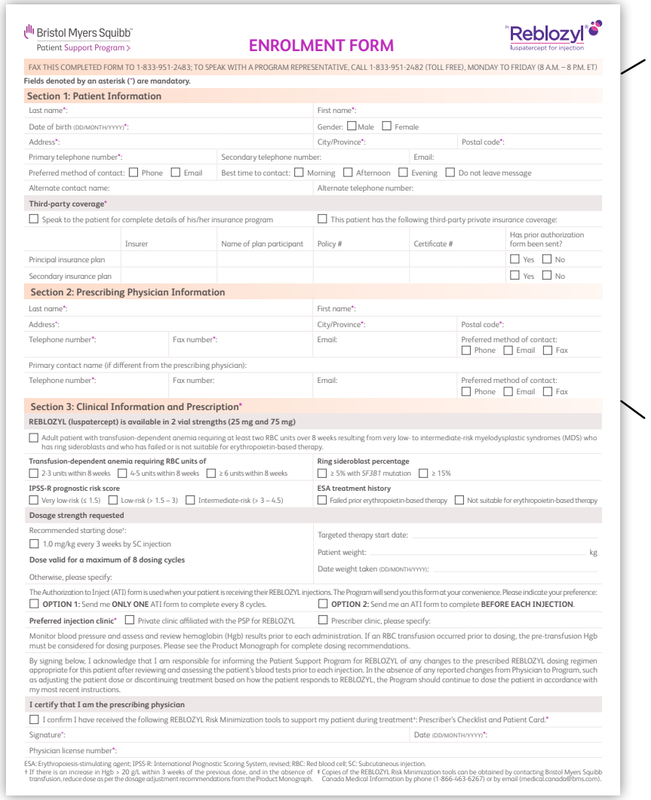
STEP 3

Support your patients during treatment with Risk Minimization Tools (Prescriber's Checklist and Patient Card)

The Program will contact you to confirm receipt of the enrolment form or if any information is missing. Once the enrolment form is complete, the Program will attempt to contact your patient within 1 business day. If the patient cannot be reached after 3 attempts, your clinic will be notified.

A closer look into the enrolment form

Patient & prescribing physician information



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Patient Support Program >

ENROLMENT FORM

Reblozyl (luspatercept for injection)

FAX THIS COMPLETED FORM TO 1-833-951-2483; TO SPEAK WITH A PROGRAM REPRESENTATIVE, CALL 1-833-951-2482 (TOLL FREE), MONDAY TO FRIDAY (8 A.M. – 8 P.M. ET)

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Primary telephone number*: | Secondary telephone number: | Email:
Preferred method of contact: ☐ Phone ☐ Email | Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening ☐ Do not leave message
Alternate contact name: | Alternate telephone number:

Third-party coverage*

☐ Speak to the patient for complete details of his/her insurance program
☐ This patient has the following third-party private insurance coverage:

	Insurer	Name of plan participant	Policy #	Certificate #	Has prior authorization form been sent?
Principal insurance plan					☐ Yes ☐ No
Secondary insurance plan					☐ Yes ☐ No

Section 2: Prescribing Physician Information

Last name*: | First name*:
Address*: | City/Province*: | Postal code*:
Telephone number*: | Fax number*: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax
Primary contact name (if different from the prescribing physician):
Telephone number*: | Fax number*: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Section 3: Clinical Information and Prescription*

REBLOZYL (luspatercept) is available in 2 vial strengths (25 mg and 75 mg)

☐ Adult patient with transfusion-dependent anemia requiring at least two RBC units over 8 weeks resulting from very low- to intermediate-risk myelodysplastic syndromes (MDS) who has ring sideroblasts and who has failed or is not suitable for erythropoietin-based therapy.

Transfusion-dependent anemia requiring RBC units of
☐ 2-3 units within 8 weeks ☐ 4-5 units within 8 weeks ☐ ≥ 6 units within 8 weeks

Ring sideroblast percentage
☐ ≥ 5% with SF3B1 mutation ☐ ≥ 15%

IPSS-R prognostic risk score
☐ Very low-risk (≤ 1.5) ☐ Low-risk (> 1.5 – 3) ☐ Intermediate-risk (> 3 – 4.5)

ESA treatment history
☐ Failed prior erythropoietin-based therapy ☐ Not suitable for erythropoietin-based therapy

Dosage strength requested

Recommended starting dose†:
☐ 1.0 mg/kg every 3 weeks by SC injection

Dose valid for a maximum of 8 dosing cycles

Otherwise, please specify:

Targeted therapy start date:
Patient weight: kg
Date weight taken (DD/MONTH/YYYY):

The Authorization to Inject (ATI) form is used when your patient is receiving their REBLOZYL injections. The Program will send you this form at your convenience. Please indicate your preference:
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Preferred injection clinic* ☐ Private clinic affiliated with the PSP for REBLOZYL ☐ Prescriber clinic, please specify:

Monitor blood pressure and assess and review hemoglobin (Hgb) results prior to each administration. If an RBC transfusion occurred prior to dosing, the pre-transfusion Hgb must be considered for dosing purposes. Please see the Product Monograph for complete dosing recommendations.

By signing below, I acknowledge that I am responsible for informing the Patient Support Program for REBLOZYL of any changes to the prescribed REBLOZYL dosing regimen appropriate for this patient after reviewing and assessing the patient's blood tests prior to each injection. In the absence of any reported changes from Physician to Program, such as adjusting the patient dose or discontinuing treatment based on how the patient responds to REBLOZYL, the Program should continue to dose the patient in accordance with my most recent instructions.

I certify that I am the prescribing physician

☐ I confirm I have received the following REBLOZYL Risk Minimization tools to support my patient during treatment†: Prescriber's Checklist and Patient Card.*

Signature*: | Date (DD/MONTH/YYYY)*:
Physician license number*:

ESA: Erythropoiesis-stimulating agent; IPSS-R: International Prognostic Scoring System, revised; RBC: Red blood cell; SC: Subcutaneous injection.
† If there is an increase in Hgb > 20 g/L within 3 weeks of the previous dose, and in the absence of transfusion, reduce dose as per the dosage adjustment recommendations from the Product Monograph. † Copies of the REBLOZYL Risk Minimization tools can be obtained by contacting Bristol Myers Squibb Canada Medical Information by phone (1-866-463-6267) or by email (medical.canada@bms.com).

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Third-party coverage*

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☐ This patient has the following third-party private insurance coverage:

	Insurer	Name of plan participant	Policy #	Certificate #	Has prior authorization form been sent?
Principal insurance plan					☐ Yes ☐ No
Secondary insurance plan					☐ Yes ☐ No

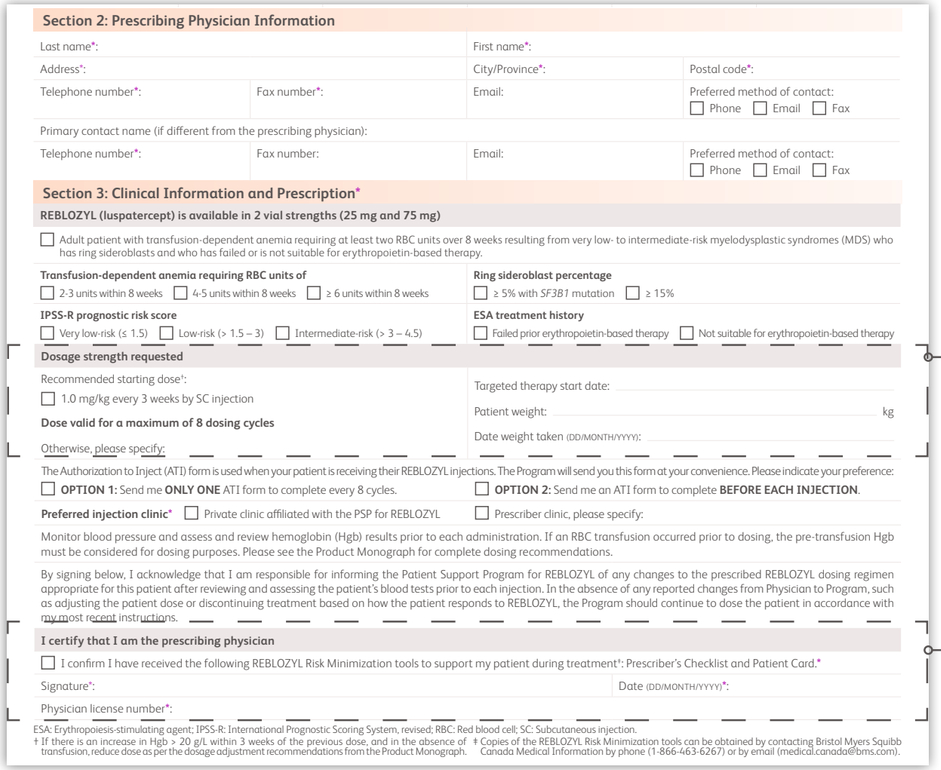
Section 2: Prescribing Physician Information

Last name*: | First name*:
Address*: | City/Province*: | Postal code*:
Telephone number*: | Fax number*: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax
Primary contact name (if different from the prescribing physician):
Telephone number*: | Fax number: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Ensure you complete **ALL** the mandatory fields (those followed by an asterisk *).

A closer look into the enrolment form

Clinical information and prescription **for MDS**



Section 2: Prescribing Physician Information

Last name*: | First name*:

Address*: | City/Province*: | Postal code*:

Telephone number*: | Fax number*: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Primary contact name (if different from the prescribing physician):

Telephone number*: | Fax number: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Section 3: Clinical Information and Prescription*

REBLOZYL (luspatercept) is available in 2 vial strengths (25 mg and 75 mg)

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Transfusion-dependent anemia requiring RBC units of
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Ring sideroblast percentage
☐ ≥ 5% with *SF3B1* mutation ☐ ≥ 15%

IPSS-R prognostic risk score
☐ Very low-risk (≤ 1.5) ☐ Low-risk (> 1.5 – 3) ☐ Intermediate-risk (> 3 – 4.5)

ESA treatment history
☐ Failed prior erythropoietin-based therapy ☐ Not suitable for erythropoietin-based therapy

Dosage strength requested

Recommended starting dose†:
☐ 1.0 mg/kg every 3 weeks by SC injection

Dose valid for a maximum of 8 dosing cycles

Otherwise, please specify:

Targeted therapy start date:

Patient weight: kg

Date weight taken (DD/MONTH/YYYY):

The Authorization to Inject (ATI) form is used when your patient is receiving their REBLOZYL injections. The Program will send you this form at your convenience. Please indicate your preference:
☐ **OPTION 1:** Send me **ONLY ONE** ATI form to complete every 8 cycles. ☐ **OPTION 2:** Send me an ATI form to complete **BEFORE EACH INJECTION**.

Preferred injection clinic* ☐ Private clinic affiliated with the PSP for REBLOZYL ☐ Prescriber clinic, please specify:

Monitor blood pressure and assess and review hemoglobin (Hgb) results prior to each administration. If an RBC transfusion occurred prior to dosing, the pre-transfusion Hgb must be considered for dosing purposes. Please see the Product Monograph for complete dosing recommendations.

By signing below, I acknowledge that I am responsible for informing the Patient Support Program for REBLOZYL of any changes to the prescribed REBLOZYL dosing regimen appropriate for this patient after reviewing and assessing the patient's blood tests prior to each injection. In the absence of any reported changes from Physician to Program, such as adjusting the patient dose or discontinuing treatment based on how the patient responds to REBLOZYL, the Program should continue to dose the patient in accordance with my most recent instructions.

I certify that I am the prescribing physician

☐ I confirm I have received the following REBLOZYL Risk Minimization tools to support my patient during treatment‡: Prescriber's Checklist and Patient Card.*

Signature*: | Date (DD/MONTH/YYYY)*:

Physician license number*:

ESA: Erythropoiesis-stimulating agent; IPSS-R: International Prognostic Scoring System, revised; RBC: Red blood cell; SC: Subcutaneous injection.
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The dosage indicated here will be valid for up to 8 dosing cycles (24 weeks), unless otherwise specified

Confirm that you have received the Risk Minimization tools by checking this box on the enrolment form

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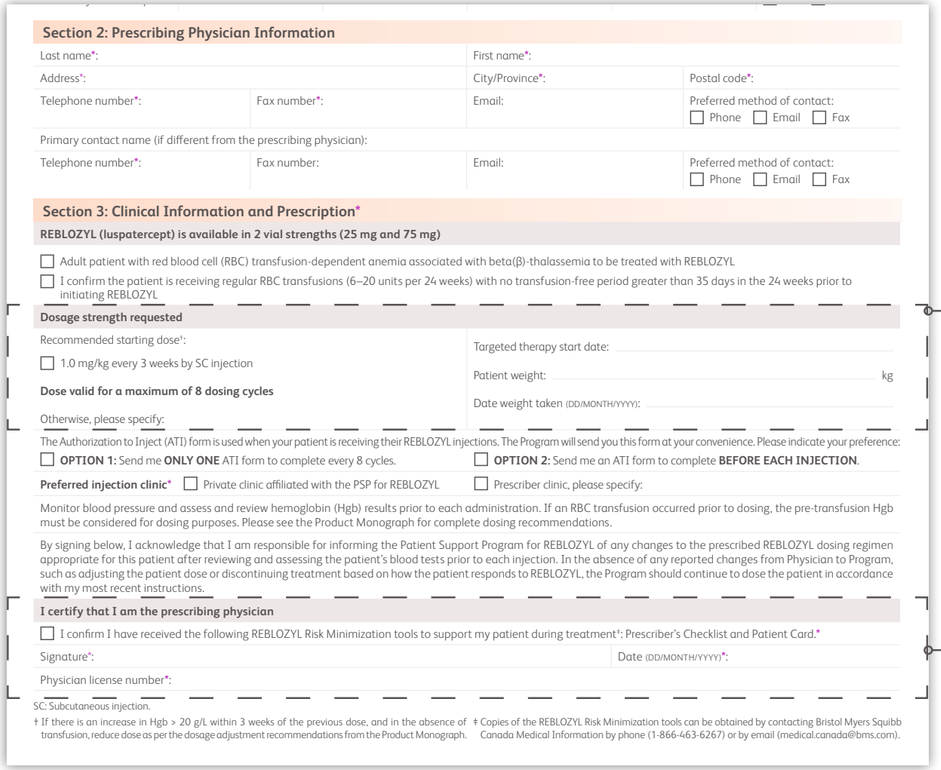
Patient Support Program >
Your patient. Our commitment.

Visit REBLOZYL.ca to download this form

A closer look into the enrolment form

Clinical information and prescription for ß-thalassemia



Section 2: Prescribing Physician Information

Last name*: | First name*:

Address*: | City/Province*: | Postal code*:

Telephone number*: | Fax number*: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Primary contact name (if different from the prescribing physician):

Telephone number*: | Fax number: | Email: | Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Section 3: Clinical Information and Prescription*

REBLOZYL (luspatercept) is available in 2 vial strengths (25 mg and 75 mg)

☐ Adult patient with red blood cell (RBC) transfusion-dependent anemia associated with beta(β)-thalassemia to be treated with REBLOZYL

☐ I confirm the patient is receiving regular RBC transfusions (6–20 units per 24 weeks) with no transfusion-free period greater than 35 days in the 24 weeks prior to initiating REBLOZYL

Dosage strength requested

Recommended starting dose†:

☐ 1.0 mg/kg every 3 weeks by SC injection

Dose valid for a maximum of 8 dosing cycles

Otherwise, please specify:

Targeted therapy start date:

Patient weight: kg

Date weight taken (DD/MONTH/YYYY):

The Authorization to Inject (ATI) form is used when your patient is receiving their REBLOZYL injections. The Program will send you this form at your convenience. Please indicate your preference:

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I certify that I am the prescribing physician

☐ I confirm I have received the following REBLOZYL Risk Minimization tools to support my patient during treatment‡: Prescriber's Checklist and Patient Card.*

Signature*: | Date (DD/MONTH/YYYY)*:

Physician license number*:

SC: Subcutaneous injection.

† If there is an increase in Hgb > 20 g/L within 3 weeks of the previous dose, and in the absence of transfusion, reduce dose as per the dosage adjustment recommendations from the Product Monograph.

‡ Copies of the REBLOZYL Risk Minimization tools can be obtained by contacting Bristol Myers Squibb Canada Medical Information by phone (1-866-463-6267) or by email (medical.canada@bms.com).

The dosage indicated here will be valid for up to 8 dosing cycles (24 weeks), unless otherwise specified

Confirm that you have received the Risk Minimization tools by checking this box on the enrolment form

Bristol Myers Squibb™

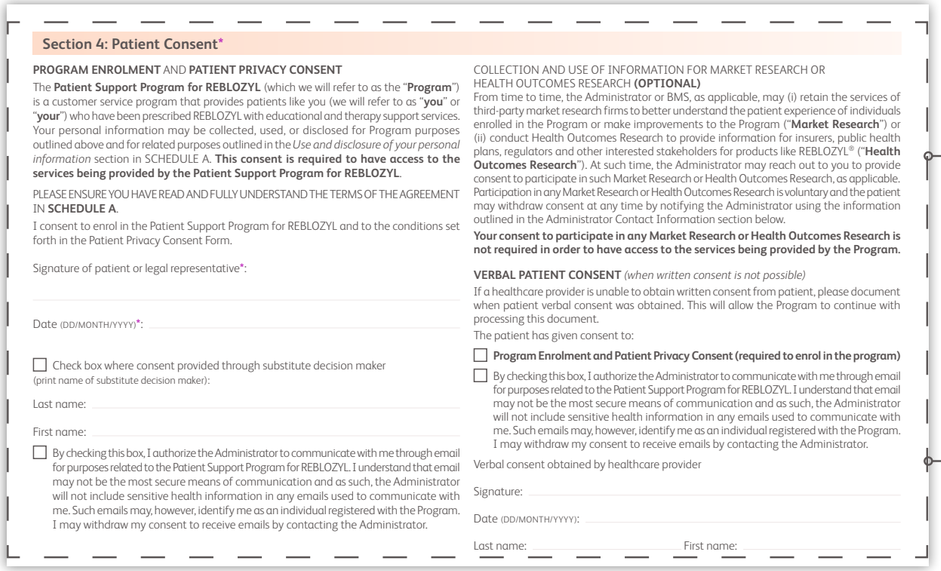
Patient Support Program >

Your patient. Our commitment.

Visit REBLOZYL.ca to download this form

A closer look into the enrolment form

Patient consent



Section 4: Patient Consent*

PROGRAM ENROLMENT AND **PATIENT PRIVACY CONSENT**

The **Patient Support Program for REBLOZYL** (which we will refer to as the "**Program**") is a customer service program that provides patients like you (we will refer to as "**you**" or "**your**") who have been prescribed REBLOZYL with educational and therapy support services. Your personal information may be collected, used, or disclosed for Program purposes outlined above and for related purposes outlined in the *Use and disclosure of your personal information* section in SCHEDULE A. **This consent is required to have access to the services being provided by the Patient Support Program for REBLOZYL.**

PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND THE TERMS OF THE AGREEMENT IN **SCHEDULE A**.

I consent to enrol in the Patient Support Program for REBLOZYL and to the conditions set forth in the Patient Privacy Consent Form.

Signature of patient or legal representative*:

Date (DD/MONTH/YYYY)*:

☐ Check box where consent provided through substitute decision maker
(print name of substitute decision maker):

Last name:

First name:

☐ By checking this box, I authorize the Administrator to communicate with me through email for purposes related to the Patient Support Program for REBLOZYL. I understand that email may not be the most secure means of communication and as such, the Administrator will not include sensitive health information in any emails used to communicate with me. Such emails may, however, identify me as an individual registered with the Program. I may withdraw my consent to receive emails by contacting the Administrator.

COLLECTION AND USE OF INFORMATION FOR MARKET RESEARCH OR HEALTH OUTCOMES RESEARCH **(OPTIONAL)**

From time to time, the Administrator or BMS, as applicable, may (i) retain the services of third-party market research firms to better understand the patient experience of individuals enrolled in the Program or make improvements to the Program ("**Market Research**") or (ii) conduct Health Outcomes Research to provide information for insurers, public health plans, regulators and other interested stakeholders for products like REBLOZYL® ("**Health Outcomes Research**"). At such time, the Administrator may reach out to you to provide consent to participate in such Market Research or Health Outcomes Research, as applicable. Participation in any Market Research or Health Outcomes Research is voluntary and the patient may withdraw consent at any time by notifying the Administrator using the information outlined in the Administrator Contact Information section below.

Your consent to participate in any Market Research or Health Outcomes Research is not required in order to have access to the services being provided by the Program.

VERBAL PATIENT CONSENT *(when written consent is not possible)*

If a healthcare provider is unable to obtain written consent from patient, please document when patient verbal consent was obtained. This will allow the Program to continue with processing this document.

The patient has given consent to:

☐ **Program Enrolment and Patient Privacy Consent (required to enrol in the program)**

☐ By checking this box, I authorize the Administrator to communicate with me through email for purposes related to the Patient Support Program for REBLOZYL. I understand that email may not be the most secure means of communication and as such, the Administrator will not include sensitive health information in any emails used to communicate with me. Such emails may, however, identify me as an individual registered with the Program. I may withdraw my consent to receive emails by contacting the Administrator.

Verbal consent obtained by healthcare provider

Signature:

Date (DD/MONTH/YYYY):

Last name: First name:

Ensure written consent is obtained either from the patient or legal representative

Verbal patient consent may also be obtained if written consent is not possible.
Note: Written consent is preferred

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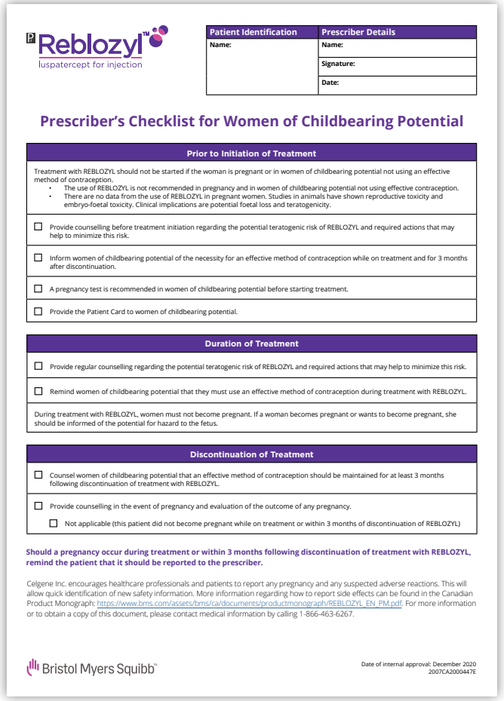
Risk Minimization Tools for REBLOZYL

Support your patients with the Risk Minimization Tools for REBLOZYL



Reblozyl™
luspatercept for injection

Patient Identification	Prescriber Details
Name:	Name:
	Signature:
	Date:

Prescriber's Checklist for Women of Childbearing Potential

Prior to Initiation of Treatment

Treatment with REBLOZYL should not be started if the woman is pregnant or in women of childbearing potential not using an effective method of contraception.
- The use of REBLOZYL is not recommended in pregnancy and in women of childbearing potential not using effective contraception.
- There are no data from the use of REBLOZYL in pregnant women. Studies in animals have shown reproductive toxicity and embryo-foetal toxicity. Clinical implications are potential foetal loss and teratogenicity.

☐ Provide counselling before treatment initiation regarding the potential teratogenic risk of REBLOZYL and required actions that may help to minimize this risk.

☐ Inform women of childbearing potential of the necessity for an effective method of contraception while on treatment and for 3 months after discontinuation.

☐ A pregnancy test is recommended in women of childbearing potential before starting treatment.

☐ Provide the Patient Card to women of childbearing potential.

Duration of Treatment

☐ Provide regular counselling regarding the potential teratogenic risk of REBLOZYL and required actions that may help to minimize this risk.

☐ Remind women of childbearing potential that they must use an effective method of contraception during treatment with REBLOZYL.

During treatment with REBLOZYL, women must not become pregnant. If a woman becomes pregnant or wants to become pregnant, she should be informed of the potential for hazard to the fetus.

Discontinuation of Treatment

☐ Counsel women of childbearing potential that an effective method of contraception should be maintained for at least 3 months following discontinuation of treatment with REBLOZYL.

☐ Provide counselling in the event of pregnancy and evaluation of the outcome of any pregnancy.

☐ Not applicable (this patient did not become pregnant while on treatment or within 3 months of discontinuation of REBLOZYL)

Should a pregnancy occur during treatment or within 3 months following discontinuation of treatment with REBLOZYL, remind the patient that it should be reported to the prescriber.

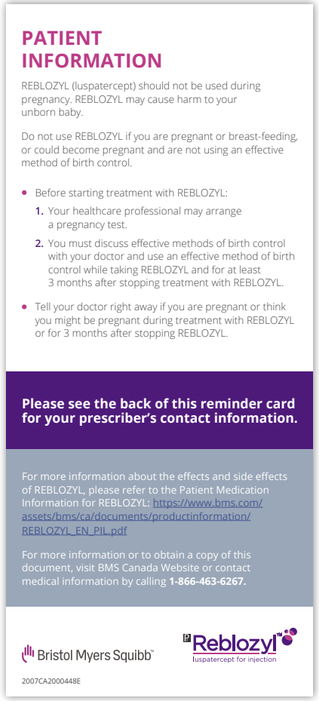
Celgene Inc. encourages healthcare professionals and patients to report any pregnancy and any suspected adverse reactions. This will allow quick identification of new safety information. More information regarding how to report side effects can be found in the Canadian Product Monograph: https://www.bms.com/assets/bms/ca/documents/productmonograph/REBLOZYL_EN_PM.pdf. For more information or to obtain a copy of this document, please contact medical information by calling 1-866-463-6267.

Bristol Myers Squibb™

Date of internal approval: December 2020
2007CA2000447E

Prescriber's Checklist

Provides important information for healthcare providers prescribing REBLOZYL for females of childbearing potential



PATIENT INFORMATION

REBLOZYL (luspatercept) should not be used during pregnancy. REBLOZYL may cause harm to your unborn baby.

Do not use REBLOZYL if you are pregnant or breast-feeding, or could become pregnant and are not using an effective method of birth control.

- Before starting treatment with REBLOZYL:
  1. Your healthcare professional may arrange a pregnancy test.
  2. You must discuss effective methods of birth control with your doctor and use an effective method of birth control while taking REBLOZYL and for at least 3 months after stopping treatment with REBLOZYL.
- Tell your doctor right away if you are pregnant or think you might be pregnant during treatment with REBLOZYL or for 3 months after stopping REBLOZYL.

Please see the back of this reminder card for your prescriber's contact information.

For more information about the effects and side effects of REBLOZYL, please refer to the Patient Medication Information for REBLOZYL: https://www.bms.com/assets/bms/ca/documents/productinformation/REBLOZYL_EN_PIL.pdf

For more information or to obtain a copy of this document, visit BMS Canada Website or contact medical information by calling **1-866-463-6267.**

Bristol Myers Squibb™ Reblozyl™ luspatercept for injection

2007CA2000448E

Reblozyl™
luspatercept for injection

Bristol Myers Squibb™

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I have been prescribed REBLOZYL

Important Contact Information

My healthcare professional who prescribed REBLOZYL:

Name: _____

Office phone number: _____

Institution address: _____

Reblozyl™ luspatercept for injection **PATIENT CARD** (For women of childbearing potential)

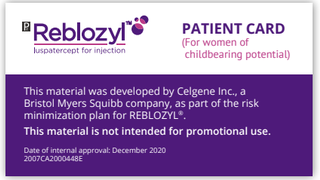
This material was developed by Celgene Inc., a Bristol Myers Squibb company, as part of the risk minimization plan for REBLOZYL®.

This material is not intended for promotional use.

Date of internal approval: December 2020
2007CA2000448E

Patient Card

Helps to remind patients that REBLOZYL should not be taken if they are pregnant or breast-feeding, or could become pregnant and are not using an effective method of birth control



Reblozyl™
luspatercept for injection

PATIENT CARD
(For women of childbearing potential)

This material was developed by Celgene Inc., a Bristol Myers Squibb company, as part of the risk minimization plan for REBLOZYL®.

This material is not intended for promotional use.

Date of internal approval: December 2020
2007CA2000448E

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Additional forms required for private clinics

Authorization to Inject for MDS

Use this form when your patient is receiving their injection at a Program affiliated private clinic.

REBLOZYL® AUTHORIZATION TO INJECT
MYELODYSPLASTIC SYNDROMES (MDS)

Patient Support Program for REBLOZYL
PLEASE COMPLETE AND FAX TO: 1-833-951-2483
FOR QUESTIONS, PLEASE CALL: 1-833-951-2482

This form should be completed ONLY in one of the following scenarios:
- Per your preference indicated in the Enrolment form
- After a period of 8 dosing cycles (24 weeks)
- Upon a change of dose

The completed form MUST be sent to the Patient Support Program for REBLOZYL at least 3 business days prior to next injection

Program Patient ID: **Pateint Initials:**

Patient Date of Birth (DD/MONTH/YYYY):

Section 1: Treatment Information
This section is to be completed by the Patient Support Program for REBLOZYL.

Next scheduled injection	Date (DD/MONTH/YYYY):		Time (24HR):
Previous injection	Date (DD/MONTH/YYYY):	Dose level (mg/kg):	Cycle number:
First injection (start date)	Date (DD/MONTH/YYYY):		
Patient weight	**Weight taken from most recent post-injection report** Weight (kg):		Date (DD/MONTH/YYYY):
Physician information	Last name: First name: Location: Pharmacy:		

Section 2: Prescription
This section is to be completed per your preference indicated in the Enrolment form, after a period of 8 dosing cycles (24 weeks), or upon a change of dose.

Patient information

Last name: First name:

Home address:

City: Province: Postal code:

Allergies and/or other medication(s) or relevant medical information:

REBLOZYL (luspatercept for injection) dose level*

☐ 1.75 mg/kg ☐ 1.33 mg/kg ☐ 1.0 mg/kg ☐ 0.8 mg/kg ☐ 0.6 mg/kg

☐ No dose required (due to hemoglobin level that is: ≥115 g/L and not influenced by recent transfusion).

Prescription valid for a maximum of 8 dosing cycles

Otherwise, please specify:

* REBLOZYL injections are recommended once every 3 weeks by subcutaneous injection. The dosage indicated on this form will be applied for a maximum of 8 cycles, unless otherwise specified. Please see the Product Monograph for complete dosing and administration instructions.

Medical license number:

By signing below, I acknowledge that I am responsible for informing the Patient Support Program for REBLOZYL of any changes to the prescribed REBLOZYL dosing regimen appropriate for this patient after reviewing and assessing the patient's blood tests prior to each injection. In the absence of any reported changes from Physician to Program, such as adjusting the patient dose or discontinuing treatment based on how the patient responds to REBLOZYL, the Program should continue to dose the patient in accordance with my most recent instructions.

Signature of Referring Physician/Hematologist: Date (DD/MONTH/YYYY):

Patient Support Program for REBLOZYL: **Phone:** 1-833-951-2482 **Fax:** 1-833-951-2483

CLEAR FORM

Reference: REBLOZYL Product Monograph. Celgene Inc.

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Reblozyl® luspatercept for injection

Complete and **send** this form to the Program at least 3 business days **prior** to next injection (from the second dose onwards).

Section 2: Prescription
This section is to be completed per your preference indicated in the Enrolment form, after a period of 8 dosing cycles (24 weeks), or upon a change of dose.

Patient information

Last name: First name:

Home address:

City: Province: Postal code:

Allergies and/or other medication(s) or relevant medical information:

REBLOZYL (luspatercept for injection) dose level*

☐ 1.75 mg/kg ☐ 1.33 mg/kg ☐ 1.0 mg/kg ☐ 0.8 mg/kg ☐ 0.6 mg/kg

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Signature of Referring Physician/Hematologist: Date (DD/MONTH/YYYY):

Completion of form ONLY required in one of the following scenarios:

- Per your preference indicated in the Enrolment Form
- After a period of 8 dosing cycles (24 weeks)
- Upon a change of dose

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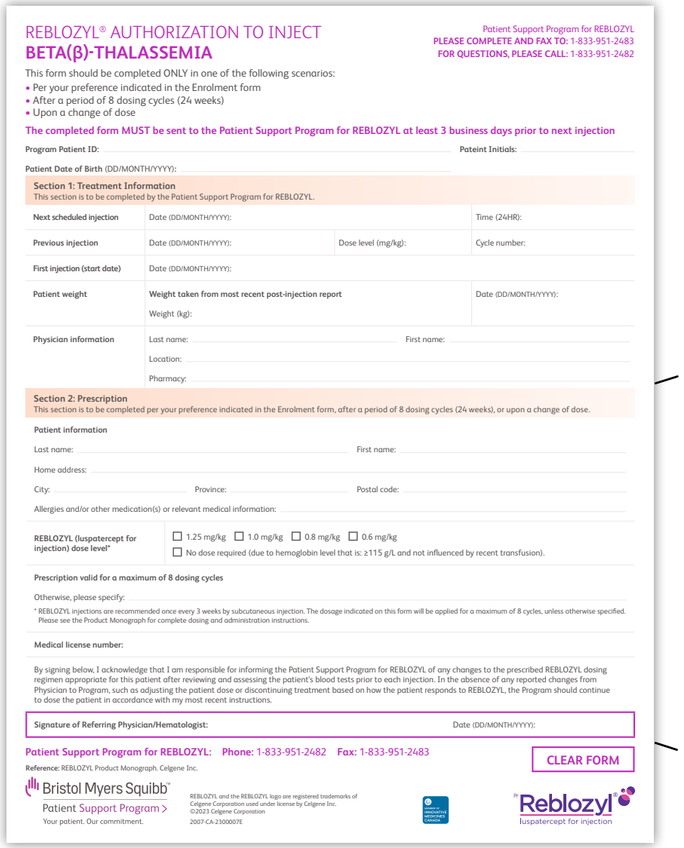
Visit REBLOZYL.ca to download this form

Additional forms required for private clinics

Authorization to Inject for ß-thalassemia

Use this form when your patient is receiving their injection at a Program affiliate private clinic.



REBLOZYL® AUTHORIZATION TO INJECT
BETA(β)-THALASSEMIA

Patient Support Program for REBLOZYL
PLEASE COMPLETE AND FAX TO: 1-833-951-2483
FOR QUESTIONS, PLEASE CALL: 1-833-951-2482

This form should be completed ONLY in one of the following scenarios:
- Per your preference indicated in the Enrolment form
- After a period of 8 dosing cycles (24 weeks)
- Upon a change of dose

The completed form MUST be sent to the Patient Support Program for REBLOZYL at least 3 business days prior to next injection

Program Patient ID: **Pateint Initials:**

Patient Date of Birth (DD/MONTH/YYYY):

Section 1: Treatment Information
This section is to be completed by the Patient Support Program for REBLOZYL.

Next scheduled injection	Date (DD/MONTH/YYYY):		Time (24HR):
Previous injection	Date (DD/MONTH/YYYY):	Dose level (mg/kg):	Cycle number:
First injection (start date)	Date (DD/MONTH/YYYY):		
Patient weight	**Weight taken from most recent post-injection report** Weight (kg):		Date (DD/MONTH/YYYY):
Physician information	Last name: First name: Location: Pharmacy:		

Section 2: Prescription
This section is to be completed per your preference indicated in the Enrolment form, after a period of 8 dosing cycles (24 weeks), or upon a change of dose.

Patient information

Last name: First name:

Home address:

City: Province: Postal code:

Allergies and/or other medication(s) or relevant medical information:

REBLOZYL (luspatercept for injection) dose level*

☐ 1.25 mg/kg ☐ 1.0 mg/kg ☐ 0.8 mg/kg ☐ 0.6 mg/kg
☐ No dose required (due to hemoglobin level that is: ≥115 g/L and not influenced by recent transfusion).

Prescription valid for a maximum of 8 dosing cycles

Otherwise, please specify:

* REBLOZYL injections are recommended once every 3 weeks by subcutaneous injection. The dosage indicated on this form will be applied for a maximum of 8 cycles, unless otherwise specified. Please see the Product Monograph for complete dosing and administration instructions.

Medical license number:

By signing below, I acknowledge that I am responsible for informing the Patient Support Program for REBLOZYL of any changes to the prescribed REBLOZYL dosing regimen appropriate for this patient after reviewing and assessing the patient's blood tests prior to each injection. In the absence of any reported changes from Physician to Program, such as adjusting the patient dose or discontinuing treatment based on how the patient responds to REBLOZYL, the Program should continue to dose the patient in accordance with my most recent instructions.

Signature of Referring Physician/Hematologist: Date (DD/MONTH/YYYY):

Patient Support Program for REBLOZYL: Phone: 1-833-951-2482 **Fax:** 1-833-951-2483

CLEAR FORM

Reference: REBLOZYL Product Monograph. Celgene Inc.

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2007-CA-230000TE

Reblozyl® luspatercept for injection

Complete and **send** this form to the Program within a minimum of 3 business days **prior** to next injection (from the second dose onwards).

Section 2: Prescription
This section is to be completed per your preference indicated in the Enrolment form, after a period of 8 dosing cycles (24 weeks), or upon a change of dose.

Patient information

Last name: First name:

Home address:

City: Province: Postal code:

Allergies and/or other medication(s) or relevant medical information:

REBLOZYL (luspatercept for injection) dose level*

☐ 1.25 mg/kg ☐ 1.0 mg/kg ☐ 0.8 mg/kg ☐ 0.6 mg/kg
☐ No dose required (due to hemoglobin level that is: ≥115 g/L and not influenced by recent transfusion).

Prescription valid for a maximum of 8 dosing cycles

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Medical license number:

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Signature of Referring Physician/Hematologist: Date (DD/MONTH/YYYY):

Completion of form ONLY required in one of the following scenarios:

- Per your preference indicated in the Enrolment Form
- After a period of 8 dosing cycles (24 weeks)
- Upon a change of dose

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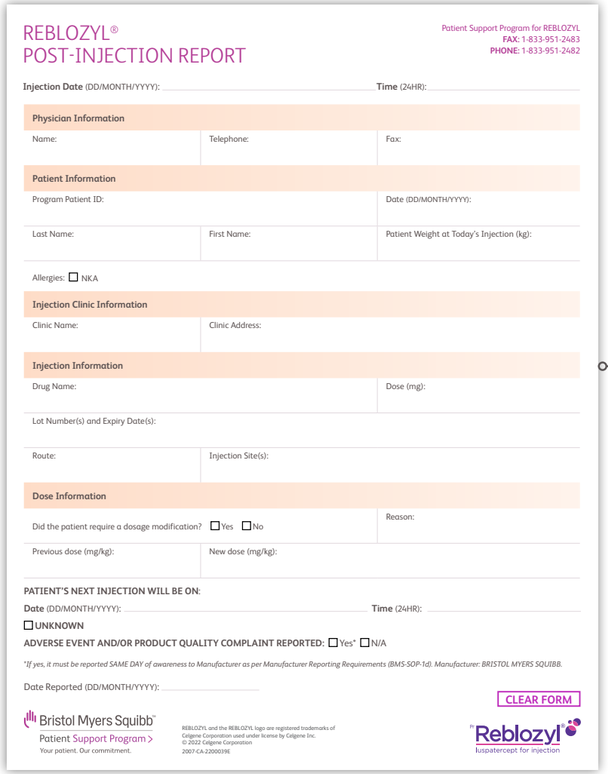
Additional forms required for private clinics

Post-injection Report



REBLOZYL®
POST-INJECTION REPORT

Patient Support Program for REBLOZYL
FAX: 1-833-951-2483
PHONE: 1-833-951-2482

Injection Date (DD/MONTH/YYYY): _____ **Time** (24HR): _____

Physician Information

Name: | Telephone: | Fax:

Patient Information

Program Patient ID: | Date (DD/MONTH/YYYY):

Last Name: | First Name: | Patient Weight at Today's Injection (kg):

Allergies: ☐ NKA

Injection Clinic Information

Clinic Name: | Clinic Address:

Injection Information

Drug Name: | Dose (mg):

Lot Number(s) and Expiry Date(s):

Route: | Injection Site(s):

Dose Information

Did the patient require a dosage modification? ☐ Yes ☐ No | Reason:

Previous dose (mg/kg): | New dose (mg/kg):

PATIENT'S NEXT INJECTION WILL BE ON:

Date (DD/MONTH/YYYY): _____ **Time** (24HR): _____

☐ **UNKNOWN**

ADVERSE EVENT AND/OR PRODUCT QUALITY COMPLAINT REPORTED: ☐ Yes* ☐ N/A

**If yes, it must be reported SAME DAY of awareness to Manufacturer as per Manufacturer Reporting Requirements (BMS-SOP-1d). Manufacturer: BRISTOL MYERS SQUIBB.*

Date Reported (DD/MONTH/YYYY): _____

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2007-CA-220003I9E

Reblozyl®
luspatercept for injection

Following each injection, **the Program will provide you with this form** when your patient is receiving their injection at a Program affiliated private clinic.

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Visit REBLOZYL.ca to download this form

For more information:

Consult the REBLOZYL Product Monograph for important information relating to contraindications, warnings, precautions, adverse reactions, interactions, dosing information, and conditions of clinical use.

The Product Monograph is also available by calling our medical information department at: **1-866-463-6267**.

Visit REBLOZYL.ca to download the PSP resources mentioned on this slide deck

REFERENCE: REBLOZYL Product Monograph. Celgene Inc.

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