FoundationNAVIGATE™ PROGRAM ENROLMENT FORM

Print Form

PLEASE ATTACH THE COMPLETED FORM TO YOUR FOUNDATION MEDICINE PORTAL ORDER OR EMAIL TO LAVAL.FMI@ROCHE.COM OR FAX 1-289-323-3789

*Required field

1. SELECTED SERVICE

☐ FoundationOne®CDx **OR** ☐ FoundationOne®Heme **OR** ☐ FoundationOne®Liquid CDx **Optional Add-on:** ☐ IHC Testing PD-L1

2. PATIENT INFORMATION

First Name*:	Last Name*:	Sex: Male ☐ Female ☐	
Date of Birth (dd/mm/yy)*:	Health Card Number:	Language Preference: ☐ English ☐ French ☐ Other:	
Address:	City:	Province:	Postal Code:
Phone Number*:	Alternate Contact (First & Last Name): Alternative Phone Number:	I authorize the program to contact "Alternate Contact" about the program and my care: ☐ Yes ☐ No	

3. DIAGNOSIS/MEDICAL HISTORY

Diagnosis*:

Previous Predictive Biomarker Test(s) Completed and Results*:

Previous Treatment(s)*: ☐ Clinical Rationale Letter attached **or** Indicate here:

Current Treatment(s)*:

4. PHYSICIAN INFORMATION

Affiliated Hospital/Centre:

Specialty:		Licence Number:	
First Name*:	Last Name*:		
Address:	City:	Province:	Postal Code:
Phone Number*:	Fax Number*:	Email Address:	

PHYSICIAN DELEGATE INFORMATION (SECONDARY CONTACT)

Specify Role:		Licence Number:	
First Name*:	Last Name*:		
Address:	City:	Province:	Postal Code:
Phone Number*:	Fax Number*:	Email Address:	

FoundationNAVIGATE email or fax or phone correspondence should be directed to:
☐ Physician (contact information above) ☐ Physician Delegate/Secondary Contact (contact information above)

Who should we contact with the coverage approval decision? ☐ Physician ☐ Patient ☐ Patient's Alternate Contact

5. PATIENT CONSENT

I have read this form, including the Authorization and Consent on the reverse of this form, or it has been read to me. I agree to enrol myself in FoundationNAVIGATE and authorize the use and disclosure of information as described in this form.

Patient/Legal Representative Signature*: _____ **Date (dd/mm/yy)*:** _____

SEE FULL PATIENT CONSENT TERMS ON REVERSE - PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND THE PATIENT CONSENT TERMS.

IMPORTANT: If unable to obtain written consent from patient please document when verbal consent was obtained and by whom. This will allow the FoundationNAVIGATE Program to continue with processing this enrolment. (Verbal consent is not applicable within Alberta or New Brunswick.)

Verbal consent obtained by: _____ **Signature:** _____ **Date (dd/mm/yy)*:** _____
(FIRST, LAST NAME)

Note to Physician: Place copy of this form in patient's medical records.

If you require this enrolment form information in an accessible format, please contact Roche at 1-800-561-1759.

FOUNDATIONNAVIGATE™

6. PATIENT ENROLMENT AUTHORIZATION AND CONSENT

Dear Roche Patient Program Enrollee ("You"):
Hoffmann-La Roche Limited ("Roche") has retained McKesson Canada Corporation ("McKesson" or "Program Administrator"), a third party service provider, to administer the FoundationNAVIGATE program (the "Program"), the purpose of which is to assist Canadian patients to obtain access to FoundationOne®CDx, FoundationOne®Heme, FoundationOne®Liquid CDx and other Next Generation Sequencing services conducted by Foundation Medicine Inc. ("FMI Services"). You have enrolled, or are applying to enrol, in the Program. While the Program Administrator and Roche endeavour to assist all applicants to a Program, neither the Program Administrator nor Roche guarantee successful or continued access to FMI Services, and Roche and the Program Administrator each reserve the right to revise or cancel any aspect of a Program at any time and without notice.

Information That May Be Collected and Used

You authorize your health care provider(s) and health benefits provider(s) to share your personal information (including personal health information) with Roche and/or McKesson Canada Corporation, Specialty Health Division ("McKesson") (collectively, "we" or "us"). This information may include relevant diagnoses, assessments, prescriptions, and financial & health benefits information.

Who May See and Use Your Information

You authorize us to use and further disclose your information to your health care providers(s), hospitals (public or private), health benefit providers, and to other people and companies assisting us with this program, for the following purposes (as applicable):

- Securing coverage for FMI services.
- Determining your eligibility for financial assistance.
- Providing education.
- Patient program administrative purposes, including quality assurance and satisfaction surveys.
- As required by law, including for the purpose of reporting any adverse drug health events to Health Canada.

You authorize us to contact you in relation to these services by mail, email, fax, telephone call or text message. You authorize us to leave messages at the provided phone number or email address, and you understand that such messages may mention the name of Roche products or services, details about your medical condition and insurance coverage and your doctor's name. Your information may be held and used in any province or country worldwide.

Aggregate Data Use

Your information may be combined with the information of other Program participants to generate aggregated data sets that do not contain personal identifiers or any information that can be linked to you or matched with other information to identify you. Aggregated data may be used and/or disclosed by Roche and companies assisting us with this program ("program partners"), by way of publications, submissions or other uses, to support clinical, regulatory, market and drug access and reimbursement decision making and program improvement, including by better understanding:

- patient populations and patient outcomes;
- the impact of clinical decision-making; and
- the patient journey, including treatment courses and outcomes in specific diseases

Refusing and Withdrawing Authorization

You may refuse to grant this authorization and may cancel this authorization at any time. Your cancellation means that we will stop using and sharing your information but does not apply to information already used or shared. To cancel this authorization, you must send a written notice to McKesson by fax, email or by mail to the address on this page. If you cancel this authorization, you understand that you will no longer be enrolled in the program or have access to any of the program services (i.e., the services discussed under the heading "Who May See and Use Your Information"). Note that if you withdraw from this program, it will not affect the care you receive from your treating physician. You may request access/correction to your personal information at any time or ask questions about privacy by contacting McKesson at the address below.

Other Terms

We do not guarantee successful or continued access to FMI services or other program services. We reserve the right to revise or cancel any aspect of the program at any time and without notice.

Patient Program Contact Details

FoundationNAVIGATE™ Program
c/o McKesson Canada Corporation, Specialty Health Division
70 Wynford Drive, P.O. Box 383, North York, ON M3C 2S7
Fax: 1-888-650-4836
Email: FoundationNavigate@patientassistance.ca

Consent Version: 06-2025

Note to Physician: Place copy of this form in patient's medical records.

If you require this enrolment form information in an accessible format, please contact Roche at 1-800-561-1759.

FoundationOne®CDx, FoundationOne®Liquid CDx, and FoundationOne®Heme are next-generation sequencing services performed by Foundation Medicine, Inc. at laboratories in the USA. Hoffmann-La Roche Limited markets these services in Canada under an exclusive license from Foundation Medicine, Inc. These services were developed and their performance characteristics determined by Foundation Medicine. As in-house laboratory-developed tests, the services have not been submitted to Health Canada for evaluation and are not subject to Health Canada approval. Reports generated from these services are prepared by Foundation Medicine, without Hoffmann-La Roche Limited's involvement, and may include scientific information about experimental medicinal products or uses that are not approved or available in Canada.

Health Care Professionals Assistance
Toll-free : 1-833-461-7567 Fax : 1-289-323-3789
Email : laval.fmi@roche.com
Patient Assistance
Toll-free: 1-888-650-4835 Fax: 1-888-650-4836
Email: foundationnavigate@patientassistance.ca
Monday – Friday: 8 AM - 8 PM ET

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