



PATIENT INFORMED CONSENT

1 I, _____ ("patient") [Patient name in block letters] hereby acknowledge that -

1.1 My doctor has prescribed the following Bayer medicine:

1.2 I confirm that I hereby provide my consent that Bayer (Propriety) Limited ("Bayer"), and/or any other authorised representative of Bayer may have access to my medical or health information in order for me to participate in the Market Access Patient Assistance Program (MAPAP). Bayer (Pty) Ltd may transfer my anonymised information to members of the Bayer Group for statistical purposes, all within and outside the South Africa.

1.3 Market Access Program - assistance with obtaining reimbursement from my medical aid for my use of the prescribed Bayer Medicine.

2 CONSENT

2.1 I hereby consent that Bayer may have access to and use all confidential, medical, personal, financial and other information in connection with the treatment, my health and my participation in the program to the extent that –

2.1.1 this use and disclosure of the information is necessary for any purpose within the ordinary course and scope of the duties of any of the health care professionals or the business activities of Bayer when conducting the program;

2.1.2 The information may be necessary to ensure continuity in the treatment as well as providing related administrative and support services to me as a member of the program.

2.2 I have had an opportunity to receive and read (or have read to me) and I fully understand the content of this consent form.

2.3 I have had enough time to ask questions about this consent form and have had these questions, if any, answered to my satisfaction by my doctor and / or Bayer.

2.4 I acknowledge and agree that -

2.4.1 all notes, reports and medical history and information in connection with the treatment and my participation in the program ("the health records") are and will remain the property of Bayer;



2.4.2 I will provide accurate information about my health status and medical history to Bayer as part of my participation in the program;

2.4.3 I understand clearly from my doctor that the prescribed medicine in question is required for the treatment of my condition. I have been informed by my doctor of the treatment options available to me, the risks, benefits and costs associated with each, and I have agreed that the prescribed medicine is required for the treatment of my condition; I also understand that Bayer manufactures and/or markets the medicine prescribed by my doctor. I understand and acknowledge that Bayer may not offer medical advice or information to me and that only my doctor may provide medical advice and information and that I may not request or expect Bayer to do so;

2.4.4 my failure to comply with any instructions by my healthcare professional may give rise to complications in respect of the treatment and may adversely affect my health:

2.4.5 the health records will not be used by Bayer for purposes other than my participation in the Market Access Program in assisting me with obtaining reimbursement from my medical scheme for the use of a prescribed Bayer medicine;

2.4.6 the health records will only be used for the purposes of my participation in the program and/or assisting me with an application, in terms of the rules of my medical scheme, for obtaining authorisation from my medical scheme for the medicines prescribed by my doctor; and

2.4.7 the medicine prescribed may not be listed on my medical scheme's formulary and may be subject to a co-payment to be made by me. Bayer cannot guarantee that the prescribed medicine will be authorised by the medical scheme.

I understand that –

2.5.1 this service is provided free of charge by Bayer and Bayer can cancel this service at any time.

2.5.2 any information obtained by Bayer relating to or about me will be kept in Bayer's possession and for such time as may be necessary due to my participation in the program and the nature of the treatment;

2.5.3 Bayer may contact me using the contact information supplied to Bayer from my doctor on the doctor's motivation form.



2.5.4 I may discuss this consent and any treatment issues with my doctor.

I specifically give permission for Bayer Pharmacovigilance to contact me and/ or my attending doctor in the case of an adverse event/ product technical complaint / usability issue or other safety related information reported. I agree the Bayer can contact my doctor for the follow-up of adverse events

2.5.5 Any information obtained by Bayer relating to or about me will be kept in Bayer's, or its affiliate companies' possession, on a database, and for such time as may be necessary due to my participation in the program, to the extent legally permissible, and the nature of the treatment and Bayer may transfer my anonymised information to members of the Bayer Group for statistical purposes, all within and outside of South Africa

2.5.6 I have been informed and understand that my personal information will be handled according to the data protection policies of Bayer and/or any applicable local data privacy laws.

2.5.7 I am free to withdraw this consent at any time provided I advise Bayer of the withdrawal of my consent in writing and that I may discuss this consent and any treatment issues with my doctor. I also have the right to verify, change or delete my information as stored by Bayer in the manner mentioned above. I shall advise Bayer in writing using the following address: za-marketaccess@bayer.com or fax no: 086 679 7237 of my intention to withdraw, verify, change, amend or delete my consent and/ or information

2.5.8 In case of any adverse event / product technical complaint / usability issue or other safety related information reported, necessary information will be forwarded to Bayer local Pharmacovigilance Unit.

3. My consent in terms of this consent form is provided of my own free will without any undue influence from any person whatsoever. I have also been provided with a copy of this signed consent. I am free to withdraw this Consent at any time provided I advise Bayer of the withdrawal in writing using the following email address: za-marketaccess@bayer.com or fax no: 086 679 7237

4. I indemnify and hold Bayer harmless against and from all losses, damages, claims and costs, arising out of or in connection with any action by Bayer, its officers, employees, agents or sub-contractors or their employees, relating to my participation in the program(s) as set out herein, to the extent that such losses, damages, claims and costs do not arise out of the negligence of Bayer.



5. My signature below indicates my understanding of, and agreement to comply with the terms of this consent form.

Signed at _____ (Place) on _____ (Date)

Signature of patient

Full Name and Surname of Patient

SA ID Number/ Passport Number

IN THE CASE OF A MINOR OR DUE TO INCAPACITY

(Proof of jurisdiction to be attached)

Signed at _____ (Place) on _____ (Date)

Signature of Guardian

Jurisdiction

Full Name and Surname of Guardian

SA ID Number/ Passport Number