DOCTOR INFORMED CONSENT

I,_____hereby give any authorized representative of Bayer, consent to interact with my patient, their medical scheme, administrator, managed care organisation or any other related party, to deal with any issue concerning the payment for the medication that I have prescribed. Any data gathered is confidential. I confirm that I have obtained my patient's written consent to provide Bayer with the aforementioned information. I am in agreement with his/her participation in the program/s.

I hereby also consent to being contacted by Bayer Pharmacovigilance Department with regards to follow up or additional information required for adverse events identified and reported.

I am free to withdraw this consent at any time, providing I advise Bayer of the withdrawal in writing using the following address: email: za-marketaccess@bayer.com or fax number: 086 646 4855

Name of institution, if any, where patient is being treated		
Practice Number		
MP Number		
Telephone numbers of doctor		
Facsimile number of doctor		
E-mail address of doctor		
Postal address of doctor		
Preferred communication (Please TICK)	Fax	Email

Signed at _____ Date _____

_____ _____

Doctor Name and Surname Doctor Signature