PATIENT AGREEMENT/INFORMED CONSENT
FOR PATIENTS TAKING SORIATANE (Acitretin, Neotigason)

Patients & their parents or guardians (where applicable*) are to complete this form.

Patient's ID#:_____

Patient's Name (First & Last):_____

Patient's Address:_____

Patient's birthdate:___/___/_____ (Month/Day/Year)

Parent or Legal Guardian Name:_____

Please read each item below and initial in the space provided to show that you understand each item. ***These must <u>also</u> be initialed by the parent or guardian of a minor patient (under age 18).*** Do not sign this consent and do not take SORIATANE (aka Neotigason; generic name, Acitretin) if there is anything that you do not understand.

1. I am female and of childbearing age (12 to 55 years of age) – Circle one
    - Yes - Proceed to the next statement
    - No - Skip to statement 5

2. I understand Soriatane (Acitretin) may cause serious birth defects and that I should not take this medication if I am pregnant or breastfeeding.

    Initials: _____

3. I have discussed with my prescriber that if I am sexually active, I will use two forms of appropriate & effective contraception (eg. oral contraceptive pill and condoms), at the same time,
    - for at least one month before taking Soriatane (Acitretin),
    - while I am taking Soriatane (Acitretin)
    - and for <u>three years</u> after stopping treatment.

    Initials: _____

4. I understand that I must inform my doctor <u>immediately</u> and stop taking Soriatane (Acitretin) if I become pregnant, or believe I might be pregnant.

    Initials: _____

5. I understand that I should not donate blood during Soriatane (Acitretin) treatment, and for at least <u>three years</u> after treatment.

    Initials: _____

6. I have discussed with my prescriber the importance of adhering to my appointments for regularly-scheduled blood tests, associated with Soriatane (Acitretin) treatment.

    Initials: _____