

**UPDATE ON SUCRAID® PRODUCT
IMMEDIATE ACTION REQUIRED
FOR ALL SUCRAID® PRESCRIPTIONS AND REFILLS AFTER JUNE 29, 2017**

Dear patients, prescribing physicians and other healthcare providers:

June 29, 2017

This letter is to update you on the limited supply of Sucraid® (sacrosidase) Oral Solution. As a temporary measure, since Sucraid® is in shortage, QOL is coordinating with FDA to provide Sucraid® from an unapproved Lot D0401 to physicians and patients/legal guardians of patients who have received information, understand the potential safety risks, and consent to the use of this product.

If you want to receive a prescription for Sucraid® after June 29, 2017, you and your doctor will have to complete the forms listed below.

To continue to get a prescription for Sucraid® (which will be **Lot D0401**), you **MUST** do the following:

1. **Communicate** with your doctor about the potential safety risks with using this lot.
2. **Patient Consent Form: Patient (or parent or guardian for minor patients) sign and date** an informed consent stating that you understand and accept the potential safety risks. **Give a copy of this document to your physician and send copies to the place[s] noted below.**
3. **Minor's Assent Form: If patient is a child aged 7 to 17 years, he or she must sign and date an assent** form stating that he or she understands the risks and assents. **Give a copy of this document to your physician and send copies to the place[s] noted below.**
4. **Physician's Acknowledgment Form:** Have **your doctor sign and date an acknowledgement** that he or she understands the manufacturing situation, the potential safety risks with using this lot, and has communicated with you about it. **The physician must send a copy of the Acknowledgment to the place[s] noted below.**
5. **Patient Questionnaire: Patients (or parent or guardian if patient under 18) fill out a questionnaire** about the use of **Lot D0401 AFTER using Sucraid® Lot D0401.**

Before You Can Receive Sucraid® Lot D0401, You Must Provide the Following:			
Each form must be signed and dated.	<i><u>Patient Consent Form</u></i>	<i><u>Minor's Assent Form</u></i>	<i><u>Physician's Acknowledgement Form</u></i>
Patients Under 7 years	Parents / Guardians	Not Required	Doctor
Patients 7 to 17 years	Parents / Guardians	Patient	Doctor
Patients 18 and Older	Patient	Not Required	Doctor

Send forms:

By email to: sucraid@onepatientservices.com

or

fax to SucraidASSIST™: 800-632-1944

Thank you for working with us through these steps.

For questions, please contact Sucraid® Patient Assistance Services: 800-705-1962.

PHYSICIAN'S ACKNOWLEDGMENT FORM – LOT D0401

Physician Acknowledgment for the Distribution of SUCRAID®

Patient name (please print): _____ **DOB:** _____

This form is to be filled out by all Physicians prescribing Sucraid® for any patient that needs a prescription filled/refilled after June 29, 2017. A separate Acknowledgment Form needs to be completed for each patient prescribed Sucraid®, even if a previous Acknowledgment Form was provided for Lot A1147, A1150, B1210, B1102, B1213, C0502, C0902, C1201, or C1102.

QOL Medical has moved the manufacture of the active ingredient in Sucraid® (sacrosidase) Oral Solution to a new facility and has also recently changed the process. There is a shortage of Sucraid® because QOL is still preparing their complete submission to allow FDA evaluation of the unapproved process and facility in order to confirm that these meet FDA's pharmaceutical standards, including the minimum current good manufacturing practice (CGMP) requirements. As a temporary measure, since Sucraid® is in shortage, QOL is coordinating with FDA to provide patients with Sucraid® from an unapproved Lot D0401. This lot of Sucraid® was manufactured with the unapproved process and facility under conditions that may not meet FDA standards for pharmaceuticals.

The recent changes to the manufacturing process have concentrated on reducing the potential for microbiological contamination of the active ingredient in order to reduce the risk of bacterial byproducts. In addition to the unapproved process and facility, QOL has also changed the standard of sterility for Sucraid® oral solution. As a result, Lot D0401 is not sterile, however the quantity of microorganisms in Lot D0401 has been tested and confirmed to be within the FDA recommended levels for oral drugs at all points throughout the manufacturing process. There is a potential risk that Lot D0401 may contain viable microorganisms (e.g. bacteria) and bacterial byproducts derived from the manufacturing process. These possible bacteria or bacterial byproducts could be a safety concern for some people, such as those who are immunocompromised. While the quantity of microorganisms in Lot D0401 has been tested and confirmed to be within the FDA recommended levels for oral drugs at all points throughout the manufacturing process, there is still a remote chance that Sucraid® from Lot D0401 may cause symptoms in some patients, such as vomiting and diarrhea.

Please promptly report any adverse events such as diarrhea, vomiting, or any unexpected adverse events to us and to the FDA. If you have evaluated the potential risks against the benefits of this product and any alternate treatments, and believe that your patient should start or continue taking Sucraid®, please complete this form and provide it to SucraidASSIST™ as soon as possible.

By signing below you acknowledge that:

- You understand the potential safety risks outlined above;
- You or a member of your clinical staff have explained to the patient with sucrase-isomaltase deficiency (CSID) or his/her guardian the potential risks of taking this Lot D0401 of Sucraid®.
 - The patient, parent or legal guardian has given his/her signed consent to you or a member of your clinical staff to take Sucraid® made from this lot; and
- You agree to inform both the manufacturer of Sucraid®, QOL Medical LLC (Phone: 1-866-469-3773 | Fax: 772-365-3375 | Email: info@qolmed.com), and the FDA at 1-888-INFO-FDA (463-6332) of adverse events that occur while the patient is taking Sucraid®.

Physician name (please print): _____

Physician signature: _____

Physician address for correspondence (Street): _____

(City, State, Zip): _____

Physician's telephone: _____ Date _____

Please fax this signed, completed form to SucraidASSIST™ at 800 632-1944.

MINOR'S ASSENT FORM

ASSENT FORM FOR CHILDREN TAKING SUCRAID®

You are being asked to read and sign this form because you take Sucraid® for a condition that causes you to be unable to digest table sugar, which is in a lot of your foods.

The company that makes Sucraid® ran out of its regular Sucraid® last year and there is not any regular Sucraid® available. However, you can choose to take another kind of Sucraid® so that you can keep taking the drug. This Sucraid® has a specific lot number on the bottle, D0401. This other Sucraid® has been tested and is very similar to the regular Sucraid® but there is a small chance that this other kind of Sucraid® could make you throw up or cause you to have a stomach ache that may be different from what you are used to having. If you do take this different Sucraid®, please let your doctor or your parents or other caregivers know right away if it causes you to have any problems.

If you do not want to receive this other kind of Sucraid®, you do not have to say yes or sign your name on this form. No one will be mad at you if you say no.

By signing your name you are saying that you have talked with your doctor or your parents/caregivers about taking this other kind of Sucraid®. If you want to receive and use this other kind of Sucraid® please sign your name.

Assent By Child

Date

DOB: _____

Age: _____

To the Physician/Clinician/Parent obtaining the assent:

If the child does not sign the form, but you believe the child has actively assented, please document on this form. State the specific behaviors (head shake yes, child said okay after you described the procedure, etc.).

Signature

Date

If the child is willing to receive and use the other kind of Sucraid® and has signed or provided active assent, fax a copy of this form to SucraidASSIST™ at Fax: 800-632-1944.

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**TO BE FILLED OUT AFTER TAKING SUCRAID® FROM
LOT NUMBER D0401 RELEASED DURING SUCRAID® SHORTAGE**

PATIENT QUESTIONNAIRE

Sucraid® (sacrosidase) Oral Solution May Be Completed by the Patient or Patient's Parent or Guardian

Patient name _____ DOB: _____ Phone: _____
Parent/Guardian name (if not completed by patient) _____ Date _____
Lot Number of Sucraid®: _____

1. When did you first start taking Sucraid® (any lot)?

Month: _____ Year: _____

2. Before you started taking Sucraid®, what were your main symptoms? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Excessive gassiness |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Abdominal cramps or abdominal pain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Other(s) _____ |
| <input type="checkbox"/> Weight loss | |

3. What is your age? _____ months old, OR _____ years old

4. When did you start taking Sucraid® from this lot number D0401?

Month: _____ Year: _____

Since you started taking the Sucraid® lot number D0401 as indicated in #4:

5. Have you noticed any increase in your digestive symptoms (as indicated in #2) between previous lots and this lot of Sucraid®?

Yes No

If yes, what symptoms increased, and how many times each day did you have these symptoms?

Symptom: _____ How many times each day _____

Symptom: _____ How many times each day _____

Symptom: _____ How many times each day _____

6. Have you experienced any side effects since taking this lot of Sucraid®?

Yes No

If so, please describe: _____

7. Have you noticed a change in the color of this lot of Sucraid®?

Yes No

If so, please describe: _____

8. What other changes have you noticed in this lot of Sucraid®? Check all that apply.

Change in taste. Please describe _____

Change in smell. Please describe _____

Change in something else. Please specify and describe _____

No change

**TO BE FILLED OUT AFTER TAKING SUCRAID® FROM
LOT NUMBER D0401 RELEASED DURING SUCRAID® SHORTAGE**

9. **Have you noticed any other significant symptoms that you believe are related to this lot D0401 of Sucraid®?** Please describe _____

HIPAA Statement

Authorization to Use and Disclose Protected Health Information (“Authorization”): I authorize my pharmacy, Accredo Health Group, Inc. (Accredo), QOL Medical, LLC, the maker of Sucraid®, One Patient Services, LLC, Sucraid® support service provider, dietary consultants, my physicians, and other healthcare providers, pharmacists, insurers, and any agent or representative of any of these parties (collectively, “Authorized Parties”) to obtain individually identifiable health information (“IIHI”) regarding me and my medical condition, symptoms, treatments, family medical history, insurance coverage and payment history, and diet, and to collect, use, and disclose my IIHI among each other to/from third parties (which may include insurers, public funding programs, social workers, advocacy organizations, assistance organizations, healthcare providers, dietary consultants, and other persons or entities as any of the Authorized Parties may deem appropriate) to: (1) coordinate my treatment; (2) facilitate reimbursement support and obtain payment for my treatment; (3) provide me and my healthcare providers with free educational materials, dietary support, and/or peer consultation (4) conduct healthcare marketing activities, including those for which Accredo or One Patient Services, LLC receives compensation (5) conduct clinical assessments regarding therapeutic response to Sucraid® and (6) carry out any other purpose required or permitted by law. I understand that any of the Authorized Parties may need to contact me for additional information. For purposes of this authorization, I understand that my IIHI includes any individually identifiable information about me such as my social security number, contact information, medical condition or other health information, and treatment and payment history relating to my past, present, and future use of Sucraid® and other healthcare items or services. I understand that once my information is disclosed under this authorization, it may be further disclosed and no longer protected by federal confidentiality laws. I understand that treatment by my physician and payment, enrollment, or eligibility to receive Sucraid® is not conditioned upon the signing of this authorization. However, if I refuse to sign this authorization, my ability to receive support services related to my use of Sucraid® may be limited. I understand that this authorization will remain in effect until the later of ten (10) years from the date of my signature or five (5) years following my discontinuance of purchase of Sucraid® unless I revoke it by sending written notice to the One Patient Services Manager at One Patient Services, 7003 Presidents Drive, Suite 800, Orlando, FL 32809. If I revoke this authorization, One Patient Services, LLC will communicate my revocation to the Authorized Parties and will stop using and disclosing my information as soon as possible. However, my revocation will not affect any prior use or disclosure of IIHI made in reliance on this authorization and my revocation will not affect my treatment by my physician. If I have questions about disclosures of my IIHI, I may contact the Privacy Officer at One Patient Services at sucraid@onepatientservices.com. I understand that I have the right to receive a copy of this authorization. I further understand that I have the right at any time to refuse nursing support, dietary support or peer consultation.

Patient Name (print) _____ Date _____
Patient Signature (or representative) _____ Relationship to Patient (if applicable) _____

When you have completed the questionnaire, please send the completed questionnaire by email to sucraid@onepatientservices.com or by mail to (using the postage paid envelope).

Postage paid envelope to:

One Patient Services
2016 Patient Questionnaire
7003 Presidents Drive; Suite 800
Orlando, Florida 32809

Email to: sucraid@onepatientservices.com

If you have any questions about this questionnaire, you may call SucraidASSIST™ at 1-800-705-1962.
Thank you for your time and assistance.