

ACTEMRA® (tocilizumab) FOR RHEUMATOID ARTHRITIS ENROLMENT FORM

- ☐ Initial Treatment
☐ Change Dose
☐ Renewal

*Required field

PROGRAM FAX #: 1-888-532-1198 TEL #: 1-888-748-8926

1. PATIENT INFORMATION

Last Name*		First Name*		Sex* M <input type="checkbox"/> F <input type="checkbox"/>
Date of Birth (dd/mm/yy)*				
Allergies*		Diagnosis*		
Current Medications*				
CONTACT INFORMATION				
Address				
City, Province		Postal Code	Email Address	
Phone (Home)*	Phone (Cell)	Phone (Work)	Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	

2. PHYSICIAN INFORMATION

Physician Name		
Address		
City, Province	Postal Code	
Phone*	Fax*	
Physician information/Office stamp		

3. PRESCRIPTION INFORMATION

ACTEMRA® IV (tocilizumab)† Infuse over 60 minutes every 4 weeks: <input type="checkbox"/> ACTEMRA 4 mg/kg x ____ kg = ____ mg <input type="checkbox"/> ACTEMRA 8 mg/kg x ____ kg = ____ mg Repeats (#):	ACTEMRA® SC (tocilizumab) 162 mg injection: <input type="checkbox"/> PFS (Pre-Filled Syringe) or <input type="checkbox"/> ACTPen (AutoInjector); Frequency: <input type="checkbox"/> Biweekly or <input type="checkbox"/> Weekly In the event that patient is unable to receive reimbursement for ACTPen, do you permit PFS as alternative? <input type="checkbox"/> Yes <input type="checkbox"/> No PFS (Pre-Filled Syringe): Repeats (1 repeat=1 box of 4 syringes): <input type="checkbox"/> 3 boxes (12 syringes) <input type="checkbox"/> 6 boxes (24 syringes) <input type="checkbox"/> 12 boxes (48 syringes) <input type="checkbox"/> OTHER: _____	ACTPen (AutoInjector): Repeats (1 repeat=1 box of 4 autoinjectors): <input type="checkbox"/> 3 boxes (12 autoinjectors) <input type="checkbox"/> 6 boxes (24 autoinjectors) <input type="checkbox"/> 12 boxes (48 autoinjectors) <input type="checkbox"/> OTHER: _____
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Prescribed as Monotherapy? ☐ Yes ☐ No

ACTEMRA should be given in combination with methotrexate or other DMARDs. ACTEMRA may also be given as monotherapy in cases of intolerance to MTX or where treatment with MTX is not appropriate.†

4. PRN MEDICATIONS FOR INFUSION REACTIONS

- ☐ PRN medications approved ☐ PRN medications not required ☐ Approved meds checked below

In the event of an infusion reaction, any/all of the following medications/treatments may be given to the patient unless otherwise indicated.

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen 325-650 mg PO PRN q 4-6 hours, for pain and fever, chills | <input type="checkbox"/> Hydrocortisone 100 mg IV PRN x 1 severe allergic/anaphylactic reaction |
| <input type="checkbox"/> Dimenhydrinate 25-50 mg PO/IV PRN q 4 hours, for nausea and vomiting | <input type="checkbox"/> Oxygen via mask/nasal prongs PRN for shortness of breath, wheezing |
| <input type="checkbox"/> Diphenhydramine 25-50 mg PO/IV/IM PRN q 4-6 hours for itching, urticaria, pruritus, hives | <input type="checkbox"/> Salbutamol 2 puffs q 4-6 hours via aerochamber PRN for dyspnea, wheezing |
| <input type="checkbox"/> Epinephrine (1:1000) 0.01 mL/kg (max. 0.5 mL) SC/IM PRN q 10-15 minutes x 2 for severe anaphylactic reaction | <input type="checkbox"/> OTHER: _____ |

Physician Signature*	Date (dd/mm/yy)*
Comments	

5. PATIENT CONSENT

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

SEE FULL PATIENT CONSENT TERMS ON FOLLOWING PAGE - 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. This will allow Jointeffort® to continue with processing this enrolment. Written consent will be obtained prior to or at first infusion.

Verbal consent obtained by: _____ **Date (dd/mm/yy):** _____

Please refer to Product Monograph for important safety information.

This document is not intended to promote the use of any drug. It contains information related to the patient assistance program intended to help patients access their medicines prescribed by a healthcare professional.

6. PATIENT CONSENT

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 Innomar Strategies Inc. (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, pharmacies and (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 Roche products.
- Determining your eligibility for financial assistance.
- Coordinating fulfillment of your prescription.
- Coordinating infusion and/or injection services.
- Providing treatment reminders and 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.

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 Innomar Strategies Inc. by fax or by mail to the address on this page. If you cancel this authorization, you understand that we will no longer be able to provide the services.

Other Terms

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

Your doctor and other healthcare providers may receive funds from us to cover costs related to your participation in this program, such as fees for performing services that are not funded by your health benefits provider. Please feel free to ask your doctor any further questions you might have about these funds and the other options you have available to you.

Patient Program Contact Details

Roche Jointeffort Program

c/o Innomar Strategies Inc.

3470 Superior Court

Oakville, ON L6L 0C4

Tel: 1-888-748-8926

Fax: 1-888-532-1198