Print Form

Jointeffort®
A Roche Patient Assistance Program

ACTEMRA® (tocilizumab) ENROLMENT FORM for Juvenile Idiopathic Arthritis (JIA)

1. PATIENT INFORMATION

Last Name	First Name	Patient's Initials	Sex: ☐ M ☐ F
Date of Birth (dd/mm/yy)		Health Card #	
Patient/Legal Representative's Address		Email Address	
City, Province		Postal Code	
Phone (Home)	Phone (Cell)	Phone (Work)	
Current Medications:			

2. Rx - Please mark clearly

ORDER FOR ACTEMRA for JIA

☐ Initial Prescription ☐ Change Dose* ☐ Renewal (please attach information regarding patient's response to tocilizumab (include relevant labs))

For **sJIA** the recommended dose is 8 mg/kg q2wk for patients ≥ 30 kg, and 12 mg/kg q2wk for patients < 30 kg.

☐ ACTEMRA 8 mg/kg x _____ kg = _____ mg; # of **repeats** _____

☐ ACTEMRA 12 mg/kg x _____ kg = _____ mg; # of **repeats** _____

* Change in dose should only be based on a consistent change in the patient's body weight.

For **polyJIA** the recommended dose is 8 mg/kg q4wk for patients ≥ 30 kg, and 10 mg/kg q4wk for patients < 30 kg.

☐ ACTEMRA 8 mg/kg x _____ kg = _____ mg; # of **repeats** _____

☐ ACTEMRA 10 mg/kg x _____ kg = _____ mg; # of **repeats** _____

* Change in dose should only be based on a consistent change in the patient's body weight.

PRN MEDICATIONS FOR INFUSION REACTIONS

In the event of an infusion reaction, please authorize the following medications/ treatments below:

☐ Acetaminophen for pain and fever, chills Dose: _____
☐ Dimenhydrinate for nausea and vomiting Dose: _____
☐ Diphenhydramine for itching, urticaria, pruritis, hives Dose: _____
☐ Epinephrine for severe anaphylactic reaction Dose: _____
☐ PRN Medications not required: _____ (please specify)
☐ Oxygen via mask/nasal prongs PRN for shortness of breath, wheezing
☐ Salbutamol PRN for dyspnea, wheezing
☐ Other: _____
☐ Hydrocortisone given as per pediatric protocols for severe allergic/anaphylactic reaction Dose: _____

Physician Name (please print):		Date (dd/mm/yy):
City, Province		Postal Code
Physician Signature:	Physician Phone #:	Fax #:
Address of Patient/Legal Representative:	City, Province, Postal Code:	
Additional Comments:	Infusion Clinic Location:	**OR** ☐ To be determined by **Jointeffort®**

3. PATIENT CONSENT

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

SEE FULL PATIENT CONSENT TERMS ON REVERSE - PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND THE PATIENT CONSENT TERMS.

IMPORTANT: If unable to obtain written consent from patient's legal representative please document when verbal consent was obtained. This will allow Jointeffort to continue with processing this enrollment. Written consent will be obtained prior to or at first infusion.

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

Please refer to Product Monograph for important safety information.

If you require this information in an accessible format, please contact Roche at 1-800-561-1759.

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

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MEMBER OF INNOVATIVE MEDICINES CANADA PAAB

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4. PATIENT/LEGAL REPRESENTATIVE 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.

Roche 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