Print Form

Jointeffort®
A Roche Patient Assistance Program

ACTEMRA® (tocilizumab) FOR GIANT CELL ARTERITIS ENROLMENT FORM

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

☐ Initial Treatment
☐ Change Dose
☐ Renewal

*Required field

1. PATIENT INFORMATION

Last Name*	First Name*	Sex* M ☐ F ☐
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: ☐ Morning ☐ Afternoon ☐ Evening

2. PHYSICIAN INFORMATION

Physician Name:	
Address:	
City, Province:	Postal Code:
Phone*:	Fax*:
Communication preference: ☐ Fax ☐ Phone	

Physician information/Office stamp

3. DIAGNOSIS INFORMATION

GCA diagnosis
Newly diagnosed GCA: ☐
Relapsing GCA: ☐

Steroid usage
Concomitant: ☐ Yes ☐ No
Previous: ☐ Yes ☐ No

4. PRESCRIPTION INFORMATION

ACTEMRA® SC (tocilizumab) 162 mg injection:

☐ **PFS (Pre-Filled Syringe); Frequency**: ☐ **Biweekly or** ☐ **Weekly**

PFS (Pre-Filled Syringe) :

Repeats *(1 repeat=1 box of 4 syringes)*:

- ☐ 3 boxes (12 syringes)
- ☐ 6 boxes (24 syringes)
- ☐ 12 boxes (48 syringes)
- ☐ OTHER: _____

The recommended dose of ACTEMRA is 162 mg given once every week as a subcutaneous injection, in combination with a tapering course of glucocorticoids. A dose of 162 mg given once every other week as a subcutaneous injection, in combination with a tapering course of glucocorticoids, may be prescribed based on clinical considerations. ACTEMRA can be used alone following discontinuation of glucocorticoids.

5. PHYSICIAN SIGNATURE

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

6. PATIENT ENROLMENT AUTHORIZATION AND 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® Program to continue with processing this enrolment.

Verbal consent obtained by Name: _____ **Signature:** _____

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.

MEMBER OF INNOVATIVE MEDICINES CANADA

PAAB

Toll-free 1-888-748-8926
Fax: 1-888-532-1198
Monday - Friday 8 AM - 8 PM ET

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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