Patient Enrolment, Rx & Consent Form

Remicade® INFLIXIMAB

Please fax to your BioAdvance® Coordinator upon completion

BioAdvance® Coordinator:

Tel: | Fax:

Patient Information

Patient Name:

Address:

Tel. (Home): | Tel. (Other):

Date of Birth:

Office Information

Physician Name:

Nurse Name:

Office Address:

Tel. (office): | Fax (office):

Prescribing Physician Section

Please ☑ and complete the required information.

Indication: | mg/kg: | Patient Weight: | Date of Weight:

☐ Dose: mg **Exact Dose:**

Or: ☐ (Exact # of vials) 100 mg Vials

Frequency / Duration

☐ **Induction** weeks ☐ 0 ☐ 2 ☐ 6

And/Or

☐ **Maintenance:** Q weeks ☐ Weeks ☐ Repeats ☐ 52 weeks

This is

☐ **Paediatric**

For infusion reaction management: follow the current recommended paediatric protocol (9-17 years).

Infuse REMICADE® over no less than 2 hours as per REMICADE® Product Monograph

☐ **2 Hr infusion**

For infusion reaction management: follow the current recommended standard protocol.

Infuse REMICADE® over no less than 2 hours as per REMICADE® Product Monograph

☐ **1 Hr Infusion**

If my rheumatoid arthritis patient has received the last three 2-hour infusions without any type of infusion reaction, initiate following order: utilize the current shortened infusion recommended standard protocol to infuse REMICADE® over no less than 1 hour, or as tolerated, and manage infusion reactions as applicable.

Pretreatment orders

☐ **Option 1**

No pre-medications required

☐ **Option 2**

Please ☑ desired pretreatment medication(s) administered prior to infusion at clinic (indicate dose/route).

- ☐ Diphenhydramine (e.g., Benadryl**) ____ mg ____ PO or ____ IV 15-30 min prior to infusion (max 50 mg)
- ☐ Acetaminophen ____ mg PO 15-30 min prior to infusion
- ☐ Hydrocortisone ____ mg IV 15-30 min prior to infusion
- ☐ Dimenhydrinate (e.g., Gravol**) ____ mg ____ PO or ____ IV 15-30 min prior to infusion
- **Adult only** ☐ Cetirizine ____ mg PO 30 min prior to infusion
- **Paed only** ☐ Methylprednisolone ____ mg IV 15-30 min prior to infusion
- ☐ Other

TB Test

☐ Not required

☐ Positive result Date:

☐ Negative result Date:

CXR

☐ Not required

☐ Date Completed: Results:

For infusion reaction management: follow the current recommended standard protocol.

Physician Signature: | College License #: | Date†:

† Effective date. Order(s) expire one year from the date of signature.
Prescriber certification: I certify that this prescription is an original prescription and this pharmacy is the only receiver. The original will not be reused.

Pharmacy Name: | Address: | Contact:

Please see consent details on back.

Patient Signature: | Date:

I have read and understood the Patient Consent text printed on the back of this form and agree to the collection, use and disclosure of my personal information in accordance with these terms.

Patient Consent

I agree to permit my healthcare provider(s), including physician(s) or nurse(s), to disclose to the BioAdvance® Coordinator assigned to managing my patient file, or his/her replacement (where applicable) (the "BAC") my personal information in order to facilitate my enrolment in the BioAdvance® Program and facilitate the obtaining of my first REMICADE® prescription, and I agree to the BAC contacting me for such purposes. Personal information may include my name, address, date of birth, phone numbers and any other personal information, including my personal health information, such as my diagnosis and the information included on my prescription or on this Patient Enrolment, Rx & Consent Form (the "Consent Form").

My personal information will not be used or disclosed by the BAC for any purpose other than those described above unless information that identifies me directly is first removed or as is permitted or required by law. In addition, once I have been contacted by the BAC, if I elect to benefit from the services provided by the BAC, I will be required to sign another consent form with respect to the collection, use and disclosure of my personal information by the BAC.

I understand that:

- I do not have to sign this Consent Form, but if I do not, my healthcare provider(s) will not be able to disclose my personal information to the BAC and I will not be able to benefit from the services provided by the BAC (unless I contact the BAC directly myself);
- The medical treatment provided by my healthcare provider(s) will not be impacted by whether I sign this consent form or not;
- I may revoke (take back) this authorization at any time by mailing or faxing signed letter(s) of revocation to my healthcare provider(s), but if I do so, I will be unable to benefit from the services provided by the BAC;
- Revoking this authorization will prohibit disclosure of my health information by my healthcare provider(s) after the date my letter of revocation is received and processed, but will not affect the use or disclosure of information already received by the BAC;
- I am entitled to a copy of this Consent Form;
- If I want to access my patient file maintained by the BAC and/or make changes or corrections to it, I may do so by written request to the currently active BAC.

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