PATIENT SUPPORT PROGRAM

Harmony™ By ORGANON

# Enrollment Form

RENFLEXIS®
Infliximab for Injection

Tel: 1-866-556-5663 Fax: 1-866-240-4076
Email: info@harmonybyorganon.ca
Monday to Friday from 8 a.m. to 8 p.m. ET

## Patient Information

First name _____ Last name _____ Gender: M ☐ F ☐ Date of birth dd/mm/yyyy

Do you have health insurance coverage? ☐ Private ☐ Public ☐ Both

Preferred phone _____ Best time to reach you ☐ Morning ☐ Afternoon ☐ Evening Leave a message ☐ Yes ☐ No

Alternate phone _____ Email _____

Preferred language ☐ English ☐ French ☐ Other _____

Address _____ City _____ Province _____ Postal code _____

DO YOU AGREE TO BE CONTACTED BY THE PROGRAM OR ORGANON'S AGENTS FOR MARKET RESEARCH PURPOSES AND STUDIES RELATED TO THE PATIENT SUPPORT PROGRAM? ☐ YES ☐ NO

**PATIENT'S SIGNATURE OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE** _____ Date dd/mm/yyyy

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

## RENFLEXIS® Prescription Information Please ☑ and complete the required information.

| Indication: | mg/kg: | Patient weight: | Date of weight: |
|---|---|---|---|

☐ Dose: _____ mg ☐ Induction weeks ☐ Week 0 ☐ Week 2 ☐ Week 6

☐ Maintenance: every ☐ weeks Number of repeats: OR Number of months:

Duration of each infusion _____

## Pretreatment Orders

☐ **Option 1** No pre-medications required

☐ **Option 2** Please ☑ the desired pretreatment medication(s) for administration prior to infusion at the clinic (indicate dose/route)

☐ Diphenhydramine (e.g. Benadryl*) ☐ mg ☐ PO
or ☐ IV 15-30 min prior to infusion (max 50 mg)

☐ Acetaminophen (e.g. Tylenol*) ☐ 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

☐ Cetirizine (e.g. Reactine*) ☐ mg ☐ PO 30 min prior to infusion

☐ Methylprednisolone ☐ mg IV 15-30 min prior to infusion

☐ Other _____

## TB Test

☐ I confirm that TB testing has been completed for the above-named patient, and that he/she can start the treatment on RENFLEXIS®

☐ Please arrange for TB testing for the above-named patient.
☐ TB Skin Test ☐ QuantiFeron

## Chest x-ray

☐ Not required

☐ Date: _____
Results: _____

## Hepatitis B Vaccination

☐ Not required

☐ Yes _____
Date: _____

## Prescriber Information

Prescriber name _____

Phone _____ Fax _____

Address _____ Email _____

City _____ Province _____ Postal code _____

Other information/office stamp

I certify that this prescription is an original prescription and the pharmacy chosen by the patient is the only receiver. The original will not be reused.

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

**PRESCRIBER SIGNATURE** _____ Date dd/mm/yyyy