Jointeffort®
A Roche Patient Assistance Program

RITUXAN® (rituximab) for GRANULOMATOSIS with POLYANGIITIS (GPA) and MICROSCOPIC POLYANGIITIS (MPA) ENROLMENT FORM

Print Form

1. PATIENT INFORMATION

Last Name	First Name	Patient's Initials	Sex: M ☐ F ☐
Date of Birth (dd/mm/yy)	Health Card #	Email Address	
Address	City	Province	Postal Code
Phone (Home)	Phone (Cell)	Phone (Work)	
Best time to call:	Best time to Leave Message:		
Current Medications	**Allergies**	**Diagnosis**	

2. Rx - PLEASE MARK CLEARLY

RITUXAN DOSING

Calculate the patient's body surface area (BSA) using weight and height.

Weight _____ kg Height _____ cm Mitte: _____ dose(s) Repeats: _____

Patient's BSA= _____

Note: The formula for calculating BSA in the RAVE clinical trial was: BSA in m^2= (Weight in kg) ^0.425 x (Height in cm) ^0.725 x 0.007184. Note: Do not round until the end of calculation.

RITUXAN DOSE AND INFUSION FREQUENCY

Weekly dose (mg)= 375 mg/m^2 x patient's BSA m^2

Ordered RITUXAN dose= Weekly dose x 4 weeks

375 mg/m^2 x _____ = _____ x 4 (weeks) = _____

patient's BSA m^2 **weekly RITUXAN dose mg** **Ordered Dose (total over 4 weeks)**

Comments: _____

Dilute RITUXAN in: ☐ 250 mL of 0.9% Sodium Chloride Injection, USP IV

Blood Pressure Meds on Hold Y ☐ N ☐ Please specify: _____

RITUXAN should be given in combination with glucocorticoids.

PRE-MEDICATIONS ☐ Pre-medications approved ☐ Approved Pre-meds checked below

- ☐ Acetaminophen 650 mg PO 15-30 minute pre infusion
- ☐ Diphenhydramine 50 mg PO 15-30 minute pre infusion
- ☐ Methylprednisolone 100 mg IV in 50 mL 0.9% sodium chloride injection, USP 15-30 min pre infusion
- ☐ Other: _____
- ☐ **Pre-medications not required**

PRN MEDICATIONS FOR INFUSION REACTIONS ☐ PRN medications approved ☐ Approved PRN meds checked below

- ☐ Acetaminophen 325-650 mg PO PRN q 4-6 hours, for pain and fever, chills
- ☐ Dimenhydrinate 25-50 mg PO/IV PRN q 4 hours, for nausea and vomiting
- ☐ Diphenhydramine 25-50 mg PO/IV/IM PRN q 4-6 hours for itching, urticaria, pruritus, hives
- ☐ Epinephrine (1:1000) 0.01 mL/kg (max. 0.5 mL) SC/IM PRN q 10-15 minutes x 2 for severe anaphylactic reaction
- ☐ Hydrocortisone 100 mg IV PRN x 1 severe allergic/anaphylactic reaction
- ☐ Oxygen via mask/nasal prongs PRN for shortness of breath, wheezing
- ☐ Other: _____
- ☐ **PRN medications not required**

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

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 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 full indications, important warnings, precautions, adverse events and patient selection criteria.
Product monograph available upon request.

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

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MEMBER OF INNOVATIVE MEDICINES CANADA PAAB

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

4. 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**
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3470 Superior Court
Oakville, ON L6L 0C4
Tel: 1-888-748-8926
Fax: 1-888-532-1198