Jointeffort®
A Roche Patient Assistance Program

Jointeffort® PATIENT ASSISTANCE PROGRAM
RITUXAN® (rituximab) for Rheumatoid Arthritis ENROLMENT FORM

PLEASE FAX THE COMPLETED FORM TO 1-888-532-1198

1. PATIENT INFORMATION

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

2. Rx - Please mark clearly

Please consult the RITUXAN Product Monograph for important information relating to dosing, administration, adverse reactions, and drug interactions.

ORDER FOR RITUXAN ❒ 1st treatment ❒ Subsequent treatment Anticipated Infusion Date: _____

Infusion Clinic Location: _____ **OR** ❒ To be determined by **Jointeffort**

1st Treatment:

Day 1 ❒ 255 minute infusion (4.25 hrs) x 1000 mg
Day 15 ❒ 195 minute infusion (3.25 hrs) x 1000 mg
OR ❒ Alternative 120 minute infusion (2 hrs) x 1000 mg*

Subsequent treatments :

Day 1 ❒ 255 minute infusion (4.25 hrs) x 1000 mg **OR** ❒ Alternative 120 minute infusion (2 hrs) x 1000 mg*
Day 15 ❒ 195 minute infusion (3.25 hrs) x 1000 mg **OR** ❒ Alternative 120 minute infusion (2 hrs) x 1000 mg*

***Alternative 120 minute infusion is not an option for all patients. Consult Product Monograph for information on alternative administration eligibility.**

❒ Other dosing: _____

Treatment Legend

255 minute infusion (4.25 hrs): RITUXAN 1000 mg IV at a rate of 50 mg/hr for the first 30 minutes, increasing 50 mg/hr every 30 minutes as tolerated, for a maximum rate of 400 mg/hr.	**195 minute infusion (3.25 hrs):** RITUXAN 1000 mg IV can be started at a rate 100 mg/hr for the first 30 minutes, increasing 100 mg/hr every 30 minutes as tolerated, for a maximum rate of 400 mg/hr.	**120 minute infusion (2 hrs):** RITUXAN 1000 mg IV can be started at a rate of 250 mg/hr for the first 30 minutes (125 mg) and then 600 mg/hr for the next 90 minutes (875 mg). Not an option for all patients. Consult Product Monograph for information on alternative administration eligibility.

❒ Dilute RITUXAN in 250 mL of 0.9% Sodium Chloride Injection, USP IV. Other Instructions: _____

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

PRE-MEDICATIONS

❒ Acetaminophen 650 mg PO 15-30 min pre infusion
❒ Diphenhydramine 50 mg PO 15-30 min 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** _____ Please Specify

PRN MEDICATIONS FOR INFUSION REACTIONS

In the event of an infusion reaction, any/all of the following medications/treatments may be given to the patient unless otherwise indicated 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 x2 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
❒ Salbutamol 2 puffs q 4-6 hours via aerochamber PRN for dyspnea, wheezing
❒ Other: _____
❒ **PRN medications not required** _____ Please Specify

Physician Name (please print):		Physician Phone #:
Physician Signature:	Date (dd/mm/yy):	Fax #:
Address:	City, Province:	Postal Code:
Additional Comments:		

3. PATIENT 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 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):** _____

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

MEMBER OF INNOVATIVE MEDICINES CANADA

PAAB

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

67273E19 Version 05-2019

SECTION 4: PATIENT ENROLMENT AUTHORIZATION AND CONSENT

Information That May Be Collected and Used
You authorize your healthcare provider(s) and health benefits provider(s) to share your personal information (including personal health information) with Roche and/or Innomar Strategies Inc. (the company hired by Roche to administer this patient assistance program) (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 healthcare 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 Assistance Program Contact Details

Jointeffort Program
c/o Innomar Strategies Inc.
3470 Superior Court, Oakville, ON L6L 0C4
Tel: 1-855-547-3227
Fax: 1-855-647-3227

Note to Physician: Place copy of this form in patient's medical records.