Sonic Nurse Connect

ACTiv Infusion Management Program

Patient Referral for Treatment – ACTEMRA® INFUSION (tocilizumab)

SONIC NURSE CONNECT USE ONLY: Patient ID: ☐ ☐ ☐ ☐ ☐ ☐

NOTE: FOR NEW ACTiv PATIENTS PLEASE COMPLETE BOTH SIDES OF THIS FORM AND SUBMIT TO SONIC NURSE CONNECT

Step 1: PRESCRIBING DOCTOR details

First name:	Last name:
Clinic address:	
State:	Postcode:
Phone: (0)	Fax: (0)
Email:	
Provider number:	

Step 2: NEW PATIENT INFORMATION (COMPLETE FOR NEW PATIENTS ONLY)

First name:	Last name:
Gender: M ☐ F ☐	Date of birth: DD / MM / YYYY
Mailing address:	
State:	Postcode:
Phone: (0)	Mobile:
Email:	
Patient's emergency contact. Name:	Phone: (0)

Patient History

Has this patient had an ACTEMRA infusion before? No ☐ Yes ☐

Does the patient have any known contraindication to ACTEMRA? No ☐ Yes ☐

Please provide any relevant medical history, including known allergies:

Pharmacy Services (optional)

Patient has indicated they would like more information about Pharmacy Services provided by Sonic Nurse Connect No ☐ Yes ☐

PRESCRIBER ACKNOWLEDGEMENT

I hereby request administration of ACTEMRA to the above patient. I understand that this service is funded by Roche and is only available for patients prescribed and dispensed with ACTEMRA. I understand that in the rare case that a patient displays an acute reaction in the presence of a nurse, during or after an ACTEMRA infusion, the nurse may administer emergency medication in accordance with best practice.

I have explained to my patient they will be contacted by Sonic Nurse Connect to arrange an appointment for an infusion and they have provided their consent to this. I have also advised the patient that they will be required to sign a formal consent at their appointment.

Sonic Nurse Connect Australia (ABN 68 095 610 478) ("we", "us" or "our") collect personal information about you in order to complete a referral and administer treatment with ACTEMRA to patients referred to Sonic Nurse Connect by you, and for the purposes otherwise set out in our Privacy Policy at www.snc.com.au. If you do not provide this information, we may not be able to provide this service to you. This information may be disclosed to third parties that help us deliver our services (including information technology suppliers, communication suppliers and our business partners) or as required by law. The Privacy Policy explains how we will collect, use, store and disclose your personal information, and the way in which you can access and seek correction of your personal information or complain about a breach of the Privacy Act. To obtain further information you can contact us on 1800 687 726. Information on the Sonic Nurse Connect Privacy Policy is available at www.snc.com.au.

Doctor's Signature:

Date: / /

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NOTE: PLEASE COMPLETE ONLY THIS SIDE OF THE FORM FOR EXISTING ACTiv PATIENTS AND SUBMIT TO SONIC NURSE CONNECT
- When a change in dose or treatment is required, or
- To confirm a cessation or recommencement in treatment.

Step 3: ACTEMRA MEDICATION ADMINISTRATION AUTHORITY (Option A or B to be completed)

PATIENT details

First name:	Last name:
Gender: M ☐ F ☐	Date of birth: DD / MM / YYYY

A: MEDICATION ORDER

Medication	Route	Frequency	Record of ACTEMRA administration		
ACTEMRA	**IV**	**4 Weekly**	**Date**	**Time**	**Nurse Signature**
DOSE ________ mg	Dose start date: DD / MM / YYYY				
Note: If requesting an increased dose, confirm that the vial combination on the current prescription will allow this dose					**Nurse Name:**

SNC USE ONLY

B: TREATMENT CESSATION OR RECOMMENCEMENT ORDER

Temporary Treatment Cessation ☐	Permanent Treatment Cessation ☐	Recommencement of Treatment ☐

PRESCRIBING DOCTOR

Prescribing Dr Name:	Prescribing Dr Signature:	Date of Order: DD / MM / YYYY

Step 4: INFORMATION REQUIRED DUE TO REGULATORY REQUIREMENTS:

If a change in dose or treatment, is this due to an adverse event (AE)? No ☐ Yes ☐

If YES, the following must be completed:

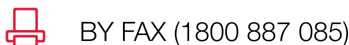
Please briefly describe the AE ....

In your opinion, was the AE caused by ACTEMRA? No ☐ Yes ☐

I am able to provide further information if required No ☐ Yes ☐

Step 5:

Send completed form to SONIC NURSE CONNECT:


BY FAX (1800 887 085)

OR EMAIL (actemra.referral@snc.com.au)

FOR FURTHER INFORMATION CALL 1800 INFUSE (1800 463 873)

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PLEASE INSTRUCT YOUR PATIENT TO BRING THEIR ACTEMRA MEDICATION TO EACH INFUSION APPOINTMENT