Sonic Nurse Connect

ACTIV Infusion Management Program

Patient Treatment Form – ACTEMRA® INFUSION

(tocilizumab)

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

PATIENT details

First name:	Last name:	
Gender: M ☐ F ☐	Date of birth: D D / M M / Y Y Y Y	
Mailing address:	State:	Postcode:

A: MEDICATION ORDER

Medication	Route	Frequency
ACTEMRA	**IV**	**4 Weekly**

DOSE

_____ mg

Dose start date: D D / M M / Y Y Y Y

Note: If requesting an increased dose, confirm that the vial combination on the current prescription will allow this dose

Record of ACTEMRA administration		
Date	**Time**	**Nurse Signature**
SNC USE ONLY		**Nurse Name:**

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: D D / M M / Y Y Y Y

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 ☐

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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