<u>MSTAC INITIAL APPLICATION</u> FOR FUNDING OF BETA-INTERFERON OR GLATIRAMER ACETATE

Please send applications to:

The Co-ordinator
MSTAC
PHARMAC
P O Box 10-254
WELLINGTON

Phone: 04 460 4990
Facsimile: 04 916 7571
Email:
mstaccoordinator@pharmac.govt.nz

*Applications **must** be **complete** and accompanied by **all** supporting data.*

Have you attached:

- ❑ MR scan reports?
- ❑ Other laboratory reports?
- ❑ Signed patient's consent form?
- ❑ Relapse history form?
- ❑ EDSS summary?

Patient Details	
Title:	Mr/Mrs/Miss/Ms/Dr
Surname:	
First Name/s:	
Address:	
Gender:	Male/Female
D.O.B:	
NHI No:	
Phone No:	
Fax No:	
Email Address:	
Cell phone No:	

Applying Practitioner	
Speciality (circle):	Neurologist or Physician
Surname:	
First Name:	
NZMC Registration Number:	
Address:	
Phone No:	
Fax No:	
Email Address:	
Cell phone No:	

Patient's General Practitioner	
Surname:	
First Name:	
Address:	
Phone No:	
Fax No:	

Patient Details	
Surname:	
First Name/s:	
NHI No:	

Details of Diagnosis		
Diagnosis of Multiple Sclerosis made:	Year:	
MR Scan:	YES/NO	(Please attach report(s) if available)
Other Supporting Reports:	YES/NO	(Please attach report(s) if available .e.g. CT Scan, EP's, CSF)
Underlying Progression Present?	YES/NO	(In addition to relapses)

Previous Treatment with Disease Modifying Therapy (DMT)

❑ Beta-interferon ❑ Copaxone ❑ Other DMT	Note: • Relapses in year before starting treatment • EDSS at time of starting treatment • Relapses occurring during treatment

Details of Treatment:

Notes:

Neurologist's Declaration

I confirm that the above and attached details are correct and that in signing this form I understand that I may be audited.

Signature: ________________________________ Date: ____________________________________

EDSS

Patient Details	
Surname:	
First Name/s:	
NHI No:	

DATE EDSS ASSESSED:
ASSESSOR:

Functional System	Score	Please Describe Main Signs	
Pyramidal			
Cerebellar			
Brainstem			
Sensory			
Bowel and Bladder			
Visual (or Optic Nerve)		VAR =	VAL =
Cerebral (or Mental)			
Other			
Measured Walking Distance without aid or rest.			
If Aids Used to Walk – type of aid used and distance walked without rest, using the aid			
EDSS SCORE			

EXPANDED DISABILITY STATUS SCALE (EDSS)

0 - Normal neurologic exam (all grade 0 in Functional Systems [FS]; Cerebral grade 1 acceptable).

1.0 - No disability, minimal signs. (one or two FS grade 1 excluding Cerebral grade 1).

1.5 - No disability, minimal signs in three or more FS (three or more FS grade 1 excluding Cerebral grade 1).

2.0 - Mild disability in one FS (one FS grade 2, others 0 or 1).

2.5 - Mild disability in two FS (two FS grade 2, others 0 or 1).

3.0 - Moderate disability in one FS (one FS grade 3, others 0 or 1) or mild disability in three or four FS (three/four FS grade 2, others 0 or 1) though fully ambulatory.

3.5 - Fully ambulatory but with moderate disability exceeding 3.0 (one FS and one or two or more grade 2; or two FS grade 3; or five FS grade 2 (with other FS 0 or 1).

4.0 - Fully ambulatory without aid or rest for 500 metres or more. One FS grade 4 (others 0 or 1) or combinations of lesser grades exceeding limits of previous steps. Able to walk without aid or rest some 500 metres.

4.5 - Fully ambulatory without aid or rest for about 300 metres. One FS grade 4 (others 0 or 1) or combinations of lesser grades exceeding limits of previous steps.

5.0 - Ambulatory without aid or rest for about 200 metres (Usual FS equivalents are one grade 5 alone, others 0 or 1; or combinations of lesser grades exceeding specifications for step 4.5).

5.5 - Ambulatory without aid or rest for about 100 metres. (Usual FS equivalents are one grade 5 alone, others 0 or 1; or combinations of lesser grades exceeding those for step 5.0).

6.0 - Intermittent or unilateral constant assistance (cane, crutch or brace) required to walk about 100 metres with or without resting. (Usual FS equivalents are combinations with more than two FS grade 3+).

6.5 - Constant bilateral assistance (canes, crutches, or braces) required to walk about 20 metres without resting. (Usual FS equivalents are combinations with more than two FS grade 3+).

7.0 - Unable to walk beyond about 5 metres even with aid, essentially restricted to wheelchair, wheels self in standard wheelchair and transfers alone. (Usual FS equivalents are combinations with more than one FS grade 4+, very rarely pyramidal grade 5 alone).

7.5 - Unable to take more than a few steps, restricted to wheelchair, may need aid in transfer, wheels self but cannot carry on in standard wheelchair a full day, may require motorised wheelchair. (Usual FS equivalents are combinations more than one FS grade 4+).

8.0 - Essentially restricted to bed or chair or perambulated in wheelchair but retains many self-care functions and generally has effective use of arms. (Usual FS equivalents are combinations with grade 4+ in more than one FS).

8.5 - Essentially restricted to bed much of the day, has some effective use of arm(s), retains some self-care functions. (Usual FS equivalents are combinations, generally 4+ in several systems).

9.0 - Helpless bed patient, can communicate and eat. (Usual FS equivalents are combinations, mostly grade 4+).

9.5 - Totally helpless bed patient, unable to communicate effectively or eat/swallow. (Usual FS equivalents are combinations, almost all grade 4+).

10 - Death due to MS.

Relapse Summary <u>(Initial Application)</u>

Patient Details	
Surname:	
First Name/s:	
NHI No:	
Date Assessed:	

*For an **initial** application for a patient who has **never been treated** with DMTs, please record details for all relapses that have occurred in the last **2 years**. For an **initial** application for a patient **currently being treated** with DMTs funded elsewhere, please record details for pre-treatment relapses in the 1-2 years before treatment and all relapses since treatment was started.*

Onset of relapse (month & year)	Duration of relapse (weeks)	New or recurrent symptom(s) of relapse. (Sufficient to change EDSS or a FS by 1 point)	Period of any hospitalisation during relapse (days)	Treatment	Relapse Monitored/confirmed by:
				o Steroids o Other	
				o Steroids o Other	
				o Steroids o Other	

CONSENT FORM FOR BETA INTERFERON SUBSIDY OR GLATIRAMER ACETATE APPLICATION

To be provided with initial application for subsidy for beta-interferon.

Patient Surname:	
First Name/s:	
NHI No:	

I consent to:

- Allow the specialist making an application for subsidy on my behalf to collect all the information required by the Multiple Sclerosis Treatment Assessment Committee (MSTAC) and/or PHARMAC via the initial application form for funding of beta-interferon or glatiramer acetate and the application form for renewal of approval (and relevant attachments).
- The secure distribution of all information contained in and relating to the application forms for funding of beta-interferon or glatiramer acetate (and relevant attachments) to members of MSTAC and, where necessary, an appeal committee and PHARMAC staff.
- The release of all information contained in and relating to the application forms for funding of beta-interferon or glatiramer acetate (and relevant attachments) on request to my specialist(s) and my General Practitioner (as identified on the forms).
- The use of all information contained in and relating to the application forms for funding of beta-interferon or glatiramer acetate (and relevant attachments) by members of MSTAC and, if necessary, an appeal committee and PHARMAC staff, for the purposes of assessing, and reviewing my eligibility for a subsidy for beta-interferon and/or for the purposes of audit.
- The distribution of information contained in the non-compulsory self-assessment form and MSQoL–54 form relating to my age, gender, medical condition and care (but excluding my name, address and/or NHI number) to PHARMAC (including person(s) contracted to PHARMAC) and use of that information by PHARMAC (including person(s) contracted to PHARMAC) for the purposes of research and/or analysis related to assessing the cost-

effectiveness of treatments for MS and making decisions regarding future funding of those treatments.

I understand that:

- The information contained in and relating to the application forms for funding of beta-interferon or glatiramer acetate (and relevant attachments) and any self assessment questionnaires I complete and return to the MSTAC co-ordinator will be held securely by the co-ordinator at PHARMAC's usual place of business or usual place of record storage, or at other premises where the co-ordinator may, in future, be based.
- I have the rights to access and correct any information contained in and relating to the application forms for funding of beta-interferon or glatiramer acetate (and relevant attachments), and any self-assessment questionnaires I complete and return to the MSTAC co-ordinator on request to the MSTAC co-ordinator.
- I may not be eligible for a subsidy for beta-interferon or glatiramer acetate.
- Although I am not required to by law, if I do not consent to the collection and use of the information in the application forms for funding of beta-interferon or glatiramer acetate (and relevant attachments), my application for beta-interferon will not be considered. If my application is approved and I later prevent access to the information (as outlined above), my subsidy may be withdrawn.
- I will not be disqualified from eligibility for funding for beta-interferon or glatiramer acetate if I do not complete PHARMAC's non-compulsory self-assessment form and MSQoL–54 questionnaires.
- If my application is approved and I subsequently become ineligible under the stopping criteria, my subsidy may be stopped.
- PHARMAC may, from time to time, review funding of beta-interferon and glatiramer acetate.

PATIENT DECLARATION

I declare that:

No information has been withheld and that this consent form may be relied upon by the specialist completing the application for subsidy of beta interferon or glatiramer acetate on my behalf.

I understand that the application forms for funding of beta-interferon or glatiramer acetate (and relevant attachments) collect personal information about me and that the information is used to assess my eligibility for subsidy for beta-interferon or glatiramer acetate and/or for the purposes of audit.

I understand that completion of PHARMAC's self-assessment and MSQoL-54 questionnaires is not compulsory.

I agree to:

Inform my neurologist if I become pregnant and/or breastfeed a child.

If required at a future date, undergo an annual blood test for neutralising anti-bodies and/or biologic responsiveness to beta-interferon or glatiramer acetate and understand that if the results indicate a lack of biologic responsiveness to beta-interferon or glatiramer acetate, my subsidy may be stopped.

Notify my neurologist and the co-ordinator of MSTAC if I stop treatment.

Signature:……………………………………………………………

Date:………………………………………