

Initial application form for imiglucerase (Cerezyme) therapy

Send completed applications to: Gaucher Panel Co-ordinator

PHARMAC
P O Box 10-254
WELLINGTON
Fax: (04) 460 4995
Phone: (04) 460 4990
Email: gaucherpanel@pharmac.govt.nz

Date of Application: _____

Patient Name:	_____							
NHI number:	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>							
Date of Birth:	____/____/____							
Gender:	Male: <input type="checkbox"/> Female: <input type="checkbox"/>							
Patient Address:	_____ (Street no. & name)							
	_____ (Suburb/City)							
	_____ (telephone no.)							

Prescribing physician /paediatrician: _____

NZMC registration no: _____

Address: _____ (Street no. & name)

_____ (Suburb/City)

_____ (Telephone, fax)

_____ (e-mail)

General Practitioner _____ (Name)

Address: _____ (Street no. & name)

_____ (Suburb/City)

_____ (Telephone, fax)

_____ (e-mail)

1. Patient History

Current Symptoms (including hospitalisations due to Gaucher disease):

Past history (including previous hospitalisations due to Gaucher disease):

Current work / school history (including number of sickness days in past 12 months):

Other medical conditions:

2. Major symptoms

Please tick those that apply and attach all relevant test reports

Haematological complications	
	Haemoglobin <95 g/L, after other causes of anaemia, such as iron deficiency have been treated or ruled out, or severe symptoms from anaemia at a higher level of haemoglobin
	Thrombocytopenia < 50 x 10 ⁹ /l on two separate occasions at least one month apart
	Bleeding complications associated with thrombocytopenia, irrespective of the platelet count.
	At least two episodes of severely symptomatic splenic infarcts confirmed by CT or other imaging of the abdomen.
	Massive symptomatic splenomegaly.
Skeletal complications	
	One acute bone crisis severe enough to require hospitalisation and or major pain management strategies.
	Radiographical MRI evidence of incipient destruction of any major joint, such as the hips or shoulder.
	Spontaneous fractures or vertebral collapse with evidence from imaging studies that recurrence is likely.
	Chronic bone pain not controlled by the administration of non-narcotic analgesics or anti-inflammatory drugs, or requiring continuous medication or causing a significant loss of time from work or school.
Hepatic complications	
	Evidence of significant liver dysfunction, such as incipient portal hypertension, attributable to Gaucher disease (treatment should start before this stage is reached).
	Significant hepatomegaly e.g., 5 cms below the right costal margin or significant abnormality of the liver function tests.
Pulmonary complications	
	Reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease.
Systemic complications	
	Growth failure in children: significant decrease in percentile linear growth over a 6-12 month period.

3. Physical examination

Date of examination: _____

Weight (kg): _____

Height (cm): _____ (if child, please attach height chart)

4. Bloods

Date	Hb	Plate-lets	AST	ALP	INR	APPT	Acid Phos.	Chito. / hr	Chito. / min

Comments: _____

Viscera size / volume

Date	Clinical: cm below costal margin		Radiology: volume (specify type of imaging used)	
	Spleen	Liver	Spleen	Liver

Comments: _____

5. Heart & Lungs

Consider if symptoms

Date	Pulse rate / min	Blood pressure (mm/Hg)	Echo (RV Pressure)	Lung function DLCO. Radiology

Comments: _____

6. Bones

Please send imaging, including reports, of hips, femur, lumbo-sacral spine and other bones clinically affected, on CD.

	Date
Plain X-ray	
MRI	
DEXA	
Symptoms	

Comments: _____

7. Neurological

Comments: _____

8. Current medications

Imiglucerase	
Bisphosphonates	
Pain relief	
Other	

9. Other comments (including main reason for initiating imiglucerase therapy)

10. Checklist

Complete reports are attached

Informed consent has been obtained from the patient (patient's guardian)

The patient / guardian has agreed to data being collected on the results of treatment.

I acknowledge that this application, if approved will be valid for 12 months only and that I will have to reapply for ongoing therapy for this patient.

The patient acknowledges that if there is not sufficient response to therapy that subsidy for ongoing therapy may not be forthcoming.

Signed: _____

Date ____ / ____ / ____