

Renewal application 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" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table>							
Date of Birth:	<table style="margin: auto;"> <tr> <td style="width: 40px; border-bottom: 1px solid black;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 40px; border-bottom: 1px solid black;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 40px; border-bottom: 1px solid black;"></td> </tr> </table>		/		/			
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1. Physical examination: Date: _____

Weight (kg)	
Height (cm) If child, please attach height chart	
Pulse	
Blood pressure	
Spleen - cm below costal margin	
Liver - cm below costal margin	

2. Bloods

Notes: New patients require 3-monthly tests
 Patients with stable disease require annual tests.

Date	Hb	Platelets	Chito. / hr	Chito. / min

3. Radiology

NB: MRI imaging must include both CD and report

New patients, and patients with unstable disease require an annual MRI

Patients with stable disease require MRI imaging every 2 - 5 years

Date of MRI:	CD Included	Report Included
Abdomen: <i>Liver volume and spleen volume</i>		
Lumbar spine: <i>Sagittal T1 & T2; Sagittal STIR</i>		
Femora (whole bone): <i>Coronal T1 & T2; Coronal STIR</i>		
An attempt at calculation of bone marrow burden score (by Maas criteria)		
Other tests: <i>(please specify)</i>		

4. Neurological

Comments: _____

5. Current medications

Imiglucerase	
Bisphosphonates	
Pain relief	
Other	

6. Current Symptoms / Wellbeing of patient over previous 12 months

7. Compliance

To the best of your knowledge patient is compliant with Cerezyme therapy **YES / NO**
The patient wishes to continue with Cerezyme therapy **YES / NO**
Do you consider that the patient continues to derive benefit from Cerezyme therapy? **YES / NO**

8. Checklist

Complete reports are attached

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: ____ / ____ / ____