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: | | | | | | | |

Date of Birth: ____/_____/_____

INSERT PATIENT STICKER HERE

1. Physical examination

Date of examination: _____

Weight (kg): _____

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

2. Bloods

New patient requires 3-monthly tests / Patient with stable disease requires annual tests.

Date	Hb	Platelets	Chito. / hr	Chito. / min

3. Viscera size / volume

Clinical: New patient requires 3-monthly tests / Patient with stable disease requires annual tests.
Radiology: New patient requires annual imaging / Patient with stable disease requires imaging every 2 years.

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

4. Heart & Lungs

Consider if patient has symptoms

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

5. Bones

New patient requires annual imaging / Patient with stable disease requires imaging every 2 years.

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	

6. Neurological

Comments:_____

_____

_____

_____

7. Current medications

Imiglucerase	15iu/kg/month	
	30iu/kg/month	
Bisphosphonates		
Pain relief		
Other		

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

_____

_____

_____

9. 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**

How is the patient receiving treatment? **AT HOME / OUTPATIENT CLINIC**

10. 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: _____ / _____ / _____