

# 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.

<b>Date</b>	
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**

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**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_