NATIONAL BLOOD AUTHORITY AUSTRALIA

# INTRAVENOUS IMMUNOGLOBULIN (IVIg)
## Authorisation Request Form (effective from 1 Sept 2015)
## NEUROLOGICAL INDICATIONS

Governance

**FOR HAEMATOLOGICAL & IMMUNOLOGICAL INDICATIONS PLEASE USE DEDICATED FORM**

**PLEASE FAX COMPLETED FORM TO RCH BLOOD BANK LABORATORY ON 9345 5817**

Once complete, signed and dated, please FAX: 9345 5817
For enquiries and urgent requests please PHONE: 9345 5829 AFTER HOURS PHONE: 9345 5829

State/Territory: Please select

Requesting Medical Officer Name: Position:

Pager/Mobile: Phone: Fax: Date:

**PATIENT DETAILS (or affix hospital label)**

Surname:
Given names:
DOB:
Gender: ☐ Female ☐ Male
UR:
Hospital:
Weight: kg Height: cm

Previous Immunoglobulin treatment:
☐ Yes ☐ No ☐ Unknown

Please provide details (including date, product and response, if known):

**PRODUCT DELIVERY INSTRUCTIONS**
Dispenser (hospital blood bank/pathology laboratory/pharmacy/private pathology)

Dispenser name: Blood Bank, Royal Children's Hospital
Street: 50 Flemington Road
Suburb: Parkville
State/Territory: VIC
Postcode: 3052
Phone: 9345 5829 Fax: 9345 5817
Email: N/A

Additional delivery instructions:

PLEASE INDICATE PATIENT DIAGNOSIS. CONSULTANT'S LETTER MAY BE ATTACHED TO DEMONSTRATE THAT ALL QUALIFYING CRITERIA HAVE BEEN MET.

- ☐ Guillain Barré syndrome
- ☐ Chronic inflammatory demyelinating polyneuropathy
- ☐ Inflammatory myopathy (please select one of the below)
  - ☐ Dermatomyositis ☐ Polymyositis
  - ☐ Inclusion body myositis - with dysphagia
- ☐ Multifocal motor neuropathy
- ☐ Myasthenia gravis
- ☐ Lambert-Eaton myasthenic syndrome
- ☐ IgM paraproteinaemic neuropathy
- ☐ Other neurological conditions (please specify)

Include relevant test results, functional criteria (e.g. non-ambulatory) and other treatments given.Nerve conduction study results ☐ Yes ☐ No Please provide details

Functional criteria/disability score (INCAT)/MRC sum score

Concomitant use of immunosuppressive therapy ☐ Yes ☐ No
If yes, please specify

Immunosuppression contraindicated ☐ Yes ☐ No
Trial of plasma exchange ☐ Yes ☐ No
If yes, please specify

Induction dose required: g OR Number of doses planned (e.g. 2x24g): DOSE/kg: N/A ☐
Date required:

Maintenance dose required: g OR Number of doses planned (e.g. 2x24g): DOSE/kg: N/A ☐
Frequency: ☐ Monthly ☐ Other (please specify) Date required:

IMPORTANT: Your patient will be allocated either **Intragam P 6%** or an imported IVIg product provided your order meets policy requirements for the supply of IVIg for clinical indications funded under the Criteria. Some hospitals have local policies for imported IVIg product. Please check with your blood and blood products Dispenser (blood bank, pathology laboratory, pharmacy or private pathology).

Please indicate your preferred imported IVIg product:

| | | | |
|---|---|---|---|
| Available until 31 December 2015* ☐ Kiovig 10% | ☐ Octagam 5% | ☐ Octagam 10% |
| * These products are available for existing patients until 30 June 2016. | | |
| Available from 1 November 2015 ☐ Privigen 10% | ☐ Flebogamma 5% | ☐ Flebogamma 10% |

OFFICE USE ONLY (Blood Service authorisation) Delegate: Designation (MO/TN/Other):

Qualifying Criteria ☐ met ☐ not met Request approved ☐ yes ☐ no Referred to JDO/IVIg Group for Review: ☐ yes ☐ no

Product: Dose: g Frequency:

Review required by: (continuing supply will be conditional on this review)

Australian Red Cross BLOOD SERVICE

NATIONAL BLOOD AUTHORITY AUSTRALIA

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## NEUROLOGICAL INDICATIONS

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Patient details:

Surname: | Given names:

DOB: | Hospital:

Requesting Medical Officer Name: | Position:

Pager/Mobile: | Phone: | Fax: | Date:

Neurologist Confirming Diagnosis:

Name: | Phone:

Email: | Mobile:

Postal Address:

Treating Medical Specialist: | Speciality:

Name: | Phone:

Email: | Mobile:

Postal Address:

IMPORTANT: The addresses above will be used for any relevant future correspondence, including the patient treatment review outcome notification form for patients requiring continuing access to government funded immunoglobulin product. For some conditions, the Criteria require review by a specialist in a specific discipline - please refer to the Criteria.

**Prescriber acknowledgement and confirmation** (to be completed by the treating medical specialist or appropriate delegate following discussion with their patient)

I acknowledge the governance and management arrangements for the appropriate supply and use of immunoglobulin products, funded under the national blood arrangements, and the provision of information required to support authorisation. To the best of my knowledge, the information provided in this form and attachments is true and correct.

I have provided and/or explained to my patient (or parent/carer/guardian) the Privacy Statement and Notice (Notice) and Patient Information Brochure and they have had the opportunity to ask questions. I believe that they are aware of and understand:

- the risks and benefits of treatment with immunoglobulin products and alternative treatments (where these exist),
- the national access conditions and governing requirements for the appropriate supply and use of immunoglobulin products under the national blood arrangements, including that immunoglobulin products may need to change from time to time
- (for patients requiring ongoing treatment only) the nature of ongoing monitoring and review and that access to product will cease if response to treatment does not demonstrate clinical benefit.

I confirm that my patient (or parent/carer/guardian) has provided express consent (explicit verbal or written consent) to:

- the collection and recording of personal information (including sensitive health information) in secure databases, held by the Australian Red Cross Blood Service (Blood Service) and the National Blood Authority (NBA),
- the use of this information by clinicians to submit a request for, and for the assessment of, initial or ongoing authorisation for access to publicly funded immunoglobulin products, against the criteria determined by clinical experts and approved by Australian governments for this purpose,
- the use of limited identifying details (for example, name, date of birth, sex and hospital identifiers) within search functions of the above mentioned databases to ensure that patients are correctly identified,
- the disclosure to and use of this information by clinicians in Australian treatment facilities that they attend for health care, in order to deliver health services according to the purposes set out in the Notice and
- the disclosure and use of this information in a manner which will not readily identify them, (such as through the removal of directly identifying personal information, or use of summary level grouped data) for the secondary purposes of: identifying priorities for research, prescriber education and training; performance evaluation and improvement of the supply, authorisation and use of immunoglobulin products; further developing the criteria upon which government policy is based; supply planning so the NBA can make sure enough Ig products are available to meet patients' needs; and enabling reporting on the program for supply, authorisation and use of publicly funded immunoglobulin products.

My patient understands that any additional use of information held by the Blood Service and NBA will only be undertaken in accordance with the requirements of the Privacy Act 1988 (Cth) and any relevant state/territory laws, and that the information may be made available for medical or public health research only with approval of a properly constituted human research ethics committee (HREC).

Signature: | Date:

Name: | Position:

The Australian Red Cross Blood Service is contracted by the National Blood Authority to perform the roles of Authoriser and Distributor of immunoglobulin products supplied and funded under the national blood arrangements.

**YOU MUST SELECT YOUR STATE OR TERRITORY BEFORE PRINTING**

PRINT