Southwest Peninsula Immunoglobulin Advisory Panel

Long Term Form 3 (Immunomodulatory)

**Are you making this application of immunoglobulin for immunomodulation** Yes[ ]  No [ ]

**If no please use form 2 (Replacement)**

This form must be signed by the consultant who will be responsible for the treatment. Please note that the Panel may be unable to reach a decision if inadequate information is provided.

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| **Has this patient met the Selection Criteria as prescribed in the DH Clinical Guidelines Yes**[ ]  **No** [ ] [**http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf**](http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf) |
| \*Panel Ref: *AIP to insert* | NHS No: | DOB: |
| Patient Name: | Trust ID Hosp no: |
| GP Details: |  |
| Height: | Weight: | Date Weighted: | M [ ]  F [ ]  |
| Consultant Name: | Speciality: | Trust /Site: |
| Consultant Email:  | Contact No: Bleep No: |
| **Proposed start date of treatment:***ongoing treatment for established follow up patients don’t need the start date.* | **Where does patient attend for treatment:***i.e.**Trust/Unit or Community hosp* |
| Pt transferred from another Trust: | Yes[ ]  No [ ]  *If yes please provide date transferred & name of hospital transferred from*. |
| Date:  | Name of Hospital:  | NHS [ ]  | Private [ ]  |
| ***NB: This will be anonymised before transmission outside clinical service*** |

***Section 1: Clinical Details:***

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| Diagnosis: |  |
| Confidence in diagnosis:  | Definite [ ]  | Highly Likely [ ]  | Possible [ ]  |

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| Stage of treatment:  New [ ]  Established [ ]  | Product:  | Treatment route: Intravenous [ ]  Sub-cutaneous [ ]  |
| Place of treatment: Home [ ]  Hospital [ ]  | Has the patient been offered home care: Yes [ ]  No [ ]  |
| Is the patient receiving treatment on homecare:  |
| Yes - offered accepted [ ]  | No – not offered [ ]  | No – offered declined [ ]   | Product not available [ ]  |
| Has training for homecare been delivered in an accredited centre: Yes [ ]  No [ ]  N/A (Hosp therapy) [ ]  |

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| **Indication for IVIg:** *Please refer to guidelines*[**http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf**](http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf) |

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| **Current Treatment** |
| Ciclosporin [ ]  | Corticosteroids [ ]  | Cyclophosphamide [ ]  | Methotrexate [ ]  |
| None [x]  | Other [ ]  | Rituximab [ ]  |  |

**Section 2:**

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| **Possible previous therapies** | **Response:** |
| Ciclosporin [ ]   |  |
| Corticosteroids [ ]   |  |
| Cyclophosphamide [ ]  |  |
| Methotrexate [ ]  |  |
| Rituximab [ ]   |  |
| Other [ ]  |  |
| None [ ]  |  |
| **Has plasma exchanged been considered**  |
| \*Tried & failed [ ]  | \*Considered but patient not suitable [ ]  | Considered but not available [ ]  |
| \*Please explain:  |

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| **What immunoglobulin treatment plan do you propose to follow? This must include;**1. Dosage: based on ideal body weight e.g. Ontario calculator [Ideal Body Weight (IBW) Calculator with IVIg Dosing](http://ivig.transfusionontario.org/dose/)
2. Proposed dosing schedule.
3. How do you intend to confirm on going need for Ig – please refer back to the guidelines
 |
|  |  Number of *g of* preparation  *given over* number of  *days*  |
| 1.
 | *Frequency:* |
|  |  |

**For Initial application, please go to section 4.**

**Section 3: At point of yearly review. Evidence of dose review and on-going need for immunoglobulin**.

*On-going need and efficacy should be demonstrated by repeat outcome measures with dose review– reimbursement is dependent on pre & post outcome measures demonstrating* ***on-going*** *need and efficacy. Some suitable outcome measures can be found in the guidelines and will depend on the condition being treated. Outcome measures should be* ***meaningful*** *in terms of showing* ***beneficial*** *impact on patient’s daily function*

**Has the patient’s condition improved since starting treatment?** Yes [ ]  No [ ]  Stable [ ]

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| Please describe measures that have been undertaken in the last year to review dosage and/or frequency. See guidelines for advice on this. [**http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf**](http://igd.mdsas.com/wp-content/uploads/Ig-PWG-Guidance-for-the-use-of-Ig-V1.3-12022019.pdf) |

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| --- | --- | --- | --- | --- | --- |
| Outcome measure 1: | *Date:* | Baseline/pre-dose value |  | Post dose |  |
| Outcome measure 2: | *Date:* | Baseline/pre-dose value |  | Post dose |  |
| Outcome measure 3: | *Date:* | Baseline/pre-dose value |  | Post dose |  |

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| **Follow up details for patients on established treatment**  |
| Date of follow up :  | Type of review : Annual review [ ]  Ongoing review [ ]  |
| Adverse reactions since last follow up: None [ ]  mild [ ]  moderate [ ]  severe [ ]  |
| Outcome of Follow-Up: Patient Died [ ]  Patient No Longer Seen [ ]  Continuing Treatment [ ]  Unknown Treatment Complete (successful) [ ]  Treatment Complete (not successful) [ ]  Transferred to Another Trust [ ]  |
| Date patient last reviewed in Clinic: Has the GP been notified of this follow-up: Yes [ ]  No [ ]   |

**Section 4:**

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| **PREPARED BY SIGNATURE:** |
| **Print Name:** | **Trust:** | **Date:** |

**Please return completed form to:**

Hospital Transfusion Team electronically to rde-tr.HTT@nhs.net

Section 5: *Panel use*

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| Panel Date:  |
| Panel Decision: Approve [ ]  Reject [ ]  |
| If reject please give details: |