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 | Other | Rituximab |  |

**Section 2:**

|  |  |  |  |
| --- | --- | --- | --- |
| **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* |
|  | *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](mailto:rde-tr.HTT@nhs.net)

Section 5: *Panel use*

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