Request for Patient Designated Plasma Protein Products

INFORMATION TO BE PROVIDED BY REQUESTING HOSPITAL/PHYSICIAN

This form must be used for initial requests, renewals and changes. Once a contract number has been assigned subsequent orders can be submitted on the Plasma Protein Products Order form referencing your contract number(s). For products licensed in Canada only, for unlicensed go to Health Canada website Special Access Programme. Incomplete forms will be returned. **Send all Request(s) with Order(s) to your local Canadian Blood Services Distribution Site 2 weeks before product is required. May take up to 30 days if Medical Approval is required.**

Section I: Requesting Hospital Details and Patient Information (complete for all request types)

Hospital Name: _____ Request Date: _____

Hospital Contact: _____ Contact # *(cell, email, etc.):* _____

Ship to (if different than ordering site): _____

Unique patient identifier: Year of Birth:

Example: Clinic tracking #. If there isn't a clinic tracking # then last four digits of health # only. (No full Personal Health #)

Ordering Physician: first and last name Contact # *(cell, email, etc.):*

Section II: Existing Patient (Change, Renewal or Further Information) ☐ or N/A ☐

Canadian Blood Services Patient #: _____ Canadian Blood Services Contract #: _____

Reason for Change or Renewal:

Section III: Product and Criteria or N/A ☐

Diagnosis:

Eloctate ☐	**Alprolix** ☐	**Hemlibra** ☐	**Panhematin** ☐	**Other Product** ☐
Criteria (one or more): Up to 100 exposure days ☐ Immune Tolerance Induction (ITI) ☐ Other (provide rationale below) ☐ If criteria for **Eloctate or Alprolix** is identified as "Other" Medical approval will be required (~30 days)	**Criteria** (one or more): < 18 years of Age ☐ Other (provide rationale below) ☐	Congenital hemophilia A (factor VIII deficiency) with inhibitor (antibodies) to factor VIII (> 0.6 Bethesda Units/mL) confirmed on more than one occasion by an appropriate assay. **And** Prescribed by a physician associated with a Hemophilia Treatment Centre.	Has the patient already been treated (restock order) ☐ how many were used? Size_____ Quantity_____ or N/A ☐ Amelioration of recurrent attacks of acute intermittent porphyria temporally related to the menstrual cycle in susceptible women, after initial carbohydrate therapy is known or suspected to be inadequate.	(may require medical review) **Product:** **Criteria/Indications for use**: (provide below) **Provide Rationale**
Date of expected transition from Eloctate/Alprolix to alternate product:				

Rationale or comments:

Section IV: Total Contract Quantities in Vials

(refer to order form for product and available sizes)

Treatment Duration in months:

Size		**Size**		**Size**		**Size**		**Size**	
Quantity		**Quantity**		**Quantity**		**Quantity**		**Quantity**	

Frequency of Pick Up: Monthly ☐ Every 2 Months ☐ Every 3 Months ☐ Other (specify) _____

Date of Next Pick Up:

Contracts will be created up to a maximum of **12 months**, a renewal request will be required every12 months

Comments:

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Section V Medical Review and SAP Information, CBS Use Only

Approved ☐	Approved with conditions ☐	Denied ☐	Reviewed ☐	Eloctate or Alprolix 30-day approval ☐	N/A ☐

See Medical Review if product criteria not met

Comments:

If medical review was obtained verbally: indicate results of review and in comment section record as per Doctor (input doctors name) initial and date.
Example: as per Dr. Jane Doe LA 2019-07-27

Completed by and date:

SAP Patient #: SAP Contract #: Entered by and date: