

**PATIENT INFORMATION**

Patient last name	First name	Middle initial	Gender M / F	Date of birth YYYY MM DD			Alberta Personal Health Number
Street address		City	Province		Postal code		
ID/client/coverage number	Coverage type <input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other						

**SPECIALIST IN HEMATOLOGY INFORMATION**

Last name		First name		Middle initial
Street address		City	Province	Postal code
Telephone number	Fax number	College of Physicians and Surgeons registration number		
Date form completed	Last consult date	Specialist in hematology signature		

**PHARMACY INFORMATION**

Pharmacy name	Telephone number	Fax number
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**INFORMATION REQUIRED**

For **INITIAL COVERAGE (new to drug)**, please complete the first two pages, and submit laboratory data and consent form as attachments

For **CONTINUED COVERAGE (on drug now or prior use of drug)**, please complete applicable sections of all pages and submit laboratory data as an attachment

**Note:** Additional pages may be attached as required; please submit all required pages and attachments together

**TREATMENT REQUESTED**

Dosage and frequency requested
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**CONFIRMATION OF DIAGNOSIS**

	Yes	No	Date (YYYY/MM/DD)	Lab result
Does the patient have a PNH granulocyte or monocyte clone size (by flow cytometry and/or FLAER test) equal to or greater than 10 per cent?	<input type="checkbox"/> granulocyte <input type="checkbox"/> monocyte	<input type="checkbox"/>		
Does the patient have a Lactate/Dehydrogenase (LDH) level at least 1.5 times the upper limit of normal?	<input type="checkbox"/>	<input type="checkbox"/>		

Please mail this request to ■ <b>Alberta Blue Cross, Clinical Drug Services</b> <b>10009 108 Street, Edmonton, Alberta T5J 3C5</b>	Or fax to ■ <b>780-401-1150</b> in Edmonton ■ <b>1-888-401-1150</b> toll free all other areas	<b>Case number</b>
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Patient's Alberta Personal Health Number (only)

**ADDITIONAL CLINICAL CRITERIA**

Does the patient have any of the following?	Yes	No	Comment
a) Thrombosis: Evidence that the patient has had a thrombotic or embolic event which required the institution of therapeutic anticoagulant therapy.	<input type="checkbox"/>	<input type="checkbox"/>	
b) Transfusions: Evidence that the patient has been transfused with at least four units of red blood cells in the last 12 months.	<input type="checkbox"/>	<input type="checkbox"/>	
c) Anemia: Evidence that the patient has chronic or recurrent anemia where causes other than hemolysis have been excluded and demonstrated by more than one measure of less than or equal to 70g/L or by more than one measure of less than or equal to 100 g/L with concurrent symptoms of anemia.	<input type="checkbox"/>	<input type="checkbox"/>	
d) Pulmonary insufficiency: Evidence that the patient has debilitating shortness of breath and/or chest pain resulting in limitation of normal activity (New York Heart Association Class III) and/or established diagnosis of pulmonary arterial hypertension where causes other than PNH have been excluded.	<input type="checkbox"/>	<input type="checkbox"/>	
e) Renal insufficiency: Evidence that the patient has a history of renal insufficiency, demonstrated by an eGFR less than or equal to 60mL/min/1.73m <sup>2</sup> , where causes other than PNH have been excluded.	<input type="checkbox"/>	<input type="checkbox"/>	
f) Smooth muscle spasm: Evidence that the patient has recurrent episodes of severe pain requiring hospitalisation and/or narcotic analgesia where causes other than PNH have been excluded	<input type="checkbox"/>	<input type="checkbox"/>	

**CONTRAINDICATIONS TO COVERAGE**

Does the patient have any of the following?	Yes	No
Small clone size - granulocyte and monocyte clone sizes below 10 percent.	<input type="checkbox"/>	<input type="checkbox"/>
Aplastic anaemia with two or more of the following: neutrophil count below 0.5 x 10 <sup>9</sup> /L, platelet count below 20 x 10 <sup>9</sup> /L, reticulocytes below 25 x 10 <sup>9</sup> /L or severe bone marrow hypocellularity.	<input type="checkbox"/>	<input type="checkbox"/>
Presence of another life threatening or severe disease where the long term prognosis is unlikely to be influenced by therapy (for example acute myeloid leukaemia or high-risk myelodysplastic syndrome).	<input type="checkbox"/>	<input type="checkbox"/>
Presence of another medical condition that might reasonably be expected to compromise a response to therapy	<input type="checkbox"/>	<input type="checkbox"/>

**IMMUNIZATION**

	Yes	No	Date (YY/MM/DD)	
All patients must receive meningococcal immunization with a quadravalent vaccine (A, C, Y and W135) at least two weeks prior to receiving the first dose of eculizumab. Treating physicians will be required to submit confirmation of meningococcal immunizations in order for their patients to continue to be eligible for treatment with eculizumab. Pneumococcal immunization with a 23-valent polysaccharide vaccine and a 13-valent conjugate vaccine, and a Haemophilus influenza type b (Hib) vaccine, must be given according to current clinical guidelines. All patients must be monitored and reimmunized according to current clinical guidelines for vaccine use.	Meningococcal (A,C,Y and W135)	<input type="checkbox"/>	<input type="checkbox"/>	
	Pneumococcal 23-valent	<input type="checkbox"/>	<input type="checkbox"/>	
	Pneumococcal 13-valent	<input type="checkbox"/>	<input type="checkbox"/>	
	Hib	<input type="checkbox"/>	<input type="checkbox"/>	

**TRANSFUSION HISTORY**

Transfusion date (YYYY/MM/DD)	RBC units	Comments

Case Number



Patient's Alberta Personal  
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**MONITORING REQUIREMENTS** (please attach the following laboratory results with each request)

- Lactate dehydrogenase (LDH)
- Full blood count and reticulocytes
- Iron studies
- Urea, electrolytes and eGFR
- PNH Granulocyte or Monocyte clone size (initial coverage and every 12 months)

**Recent clinical history** (update for each request, attach additional pages as required)

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**Progress report on the clinical symptoms that formed the basis of initial eligibility** (update annually, attach additional pages as required)

- Thrombosis   Transfusions   Anemia   Pulmonary insufficiency   Renal insufficiency   Smooth muscle spasm

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**Quality of life, through clinical narrative** (update annually, attach additional pages as required)

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Case Number

