LEMTRADA EXCEPTION DRUG STATUS (EDS) APPLICATION

Section 1 (Please print) :

PATIENT INFORMATION:	NEUROLOGIST INFORMATION:
Name: _____	**Name:** _____
Date of Birth: _____	**Address:** _____
HSN: _____	_____
Address: _____	**Postal Code:** _____
_____	**Phone:** _____ **Fax:** _____
Postal Code: _____	**Date:** _____
Phone: _____	**Date of Most Recent Consultation:** _____
Family Physician: _____	**Neurologist's Signature: (required)**
Patient Signature: (required) _____	_____ **Date:** _____

Section 2:

EDS approval will be given to patients with Relapsing Remitting Multiple Sclerosis (RRMS) who are assessed and meet <u>ALL</u> of the following criteria:

i. Active disease defined by clinical and imaging features (i.e., one new lesion); ☐ YES ☐ NO

ii. At least one relapse while on at least six months of a disease modifying therapy within the last 10 years; ☐ YES ☐ NO

iii. At least two attacks (first episode or relapse) in the previous two years, with at least one attack in the previous year; ☐ YES ☐ NO

iv. An inadequate response to a treatment course of at least six months in length (ie: at least one attack) of at least ONE disease modifying therapy listed on the SK Formulary; ☐ YES ☐ NO

Name of Drug	Duration of Treatment

v. Has a current Extended Disability Status Scale (EDSS) score of 5.0 or less ☐ YES ☐ NO

Date of most recent EDSS score: (D / M / Y) _____ EDSS Score_____

Section 3:
Contraindications to treatment:

Is the patient hypersensitive to alemtuzemab or to any ingredient in the formulation or a component of the container?	☐ YES	☐ NO
Is the patient infected with human immunodeficiency virus (HIV)?	☐ YES	☐ NO
Does the patient have active or latent tuberculosis?	☐ YES	☐ NO
Does the patient have severe active infection?	☐ YES	☐ NO
Does the patient have active malignancies?	☐ YES	☐ NO
Is the patient receiving antineoplastic or immunosuppressive therapies?	☐ YES	☐ NO
Does the patient have a history of progressive multifocal leukoencephalopathy (PML)?	☐ YES	☐ NO

Section 4:

Have the benefits/risks of this medication been discussed with your patient?	☐ YES	☐ NO
Has your patient agreed to proceed with treatment with this medication?	☐ YES	☐ NO
Have arrangements been made for the patient to be monitored following drug administration as outlined in the product monograph?	☐ YES	☐ NO

Please forward clinical history including:
a) documentation of attacks, date of onset, date of diagnosis
b) neurological findings (exam must have occurred within 90 days of the request), EDSS score
c) MRI reports/summary of findings or other significant information
d) complete medication profile

TO: Saskatchewan MS Drugs Program
Suite 7718 – 7th Floor
Saskatoon City Hospital
SASKATOON SK S7K 0M7

OR Fax: (306) 655-8404

For clinical program information: Phone (306) 655-8400

For reimbursement information: Phone 1-800-667-7578