Request for Patient Designated Plasma Protein and Related Products

INFORMATION TO BE PROVIDED BY REQUESTING HOSPITAL/PRESCRIBER

This form must be used for initial requests, renewals and changes. It is to only be used for products licensed in Canada. For unlicensed products, go to the Health Canada Special Access Program website. **Request** forms must be sent to SAPPRPRequests@blood.ca or to your **local Canadian Blood Services Distribution Site** at least 2 weeks before product is required (review may take longer if requesting access outside of listed criteria (i.e., exceptional access)). If approved, a contract number will be assigned which must be referenced on subsequent orders using the Order Form for Plasma Protein and Related Products Requiring Contracts or through the Online Ordering Portal.

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

Unless this is an emergency request, by completing and submitting this form, you agree that your patient has been provided the Privacy Notice for Patient Designated Plasma Protein and Related Products.

Hospital Information

Canadian Blood Services customer # if known:

Request Date (YYYY-MM-DD):

Requesting Hospital Name:

Ship to Hospital/Location:

Hospital Contact 1*:

Email: Phone #: Fax #:

Hospital Contact 2*:

Email: Phone #: Fax #:

Ordering Prescriber:

Email: Phone #: Fax #:

***Contract Notification will go to the Hospital Contact(s) Email/Fax#.**

Patient Information

Last Name: First Name:

Date of Birth (YYYY-MM-DD): Sex (M/F): (blank)

Height (cm): Weight (kg):

Provincial/Territorial Health Card Number:

Province/Territory of Residence: (blank)

Section II: Request Type

☐ New Patient (proceed to Section III) ☐ Renewal (includes changes) ☐ Further Information

Canadian Blood Services Patient # Canadian Blood Services Contract #

Section III: Product and Criteria

Diagnosis:

☐ **Panhematin (hemin)**

☐ 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

OR ☐ For urgent use

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Canadian Blood Services — BLOOD PLASMA STEM CELLS ORGANS & TISSUES

☐ **Hemlibra (emicizumab)**

Prescribed by a hematologist with experience in the diagnosis and management of hemophilia A

AND one of the following:

☐ Congenital hemophilia A **with inhibitors to factor VIII (> 0.6 Bethesda Units/mL)** confirmed on more than one occasion by an appropriate assay

☐ Severe congenital hemophilia A (intrinsic factor VIII level < 1%) without inhibitors who are candidates for routine prophylaxis to prevent bleeding or reduce the frequency of bleeding episodes

☐ Other** (provide rationale under Supporting Information or include an attachment)

Supporting Information (# required values)

FVIII inhibitor level (BU/mL) #	
Intrinsic FVIII level#	☐ % ☐ IU/mL
Annual bleeding rate#	
Number of target joints	
Number of hospital/clinic visits for treatment of bleeds in the past year	

☐ **Glassia (alpha-1 proteinase inhibitor)**

Glassia may be requested for adult patients that meet ALL of the following criteria:**

☐ Respirologist has confirmed the diagnosis of severe alpha-1 proteinase inhibitor (A1-PI) deficiency and clinical evidence of emphysema and indicated that patient would benefit from treatment with A1-PI product

☐ A1-PI deficiency, defined as serum A1-PI levels <11 µmol/L or < 57 mg/dL before start of the treatment

☐ Clinical evidence of obstruction (FEV1 <80%)

☐ Nonsmoker for at least 6 months

☐ Has not received a lung transplant

Supporting Information (# required values)

Baseline serum A1-PI level#	☐ µmol/L ☐ mg/dL
FEV1 (%)#	

If baseline serum A1-PI level is unavailable, please clarify below:

☐ Already on treatment with A1-PI product and no record of baseline level

☐ Other (explain):

☐ **Other Product**:**

**If patient does not meet listing criteria or product is identified as "Other", an exceptional access review will be required. Please note that additional information may be requested, and the timeline for review may increase.

Current Therapy or ☐ N/A

Product Name	Dose	Route of Administration	Frequency of Administration	Indication (e.g., prophylaxis, on demand)

New Requested Therapy or ☐ Same as Current Therapy

Product Name	Dose	Route of Administration	Frequency of Administration	Indication (e.g., prophylaxis, on demand)

Other Supporting Information (including rationale for change or initiation of therapy):

Section IV: Total Contract Quantities in Vials
(refer to order form for product and available sizes)

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

Vial Size	Total Contract Quantity	Pick Up Quantity	Frequency of Pick Up (e.g., every 3 months)	Duration of Contract (max 12 months)

Date of next product order (please comment if less than 1 week):	Comments (please include when next dose is due for STAT requests):
Expiry date of approved contract (optional to fill out for records following CBS notification):	

Section V: Urgent Medical Review and SAP Information (CBS Use Only)

The on-call medical officer can be contacted after hours to review urgent requests for **patients that meet listing criteria**. Exceptional access reviews cannot be completed by the on-call medical officer and should be sent to the PPRP Formulary team for regular review. Please forward the request form with all documentation of medical review to SAPPRPRequests@blood.ca.

Decision of urgent medical officer review: ☐ Approve 30-day supply (specify amount below) ☐ Deny

Comments:

If medical review was obtained verbally, indicate results of review in comment section above. Include: as per (physician name), initial and date (e.g., as per Dr. Jane Doe, LA 2019-07-27)

SAP Patient #:	SAP Contract #:	Completed/Entered by:	Date: