# Request for clinical approval from the East of England Immunoglobulin Assessment Panel

**Before completing this form:**

1. **The treating clinician is requested to complete all applicable fields in this form. Submitted forms without sufficient detail will be rejected.**
2. **Clinicians are expected to review clinical information, including the Selection Criteria for the indication in the** [**EOE Treatment Guidelines for Immunoglobulin**](https://www.cuh.nhs.uk/sites/default/files/misc/ImmunoglobulinTreatmentGuideline_EOEIAP.pdf) **before submitting a request for treatment.**

Clinical approval is required prior to treatment with immunoglobulins for all uncommissioned indications, for all ‘unlisted’ indications and for all **Class II to V** indications as specified in the [Regional Immunoglobulin Treatment Guidelines](https://www.cuh.nhs.uk/sites/default/files/misc/ImmunoglobulinTreatmentGuideline_EOEIAP.pdf). [See also summary on pages 3 and 4].

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| Email completed submissions to: | Add-tr.iap-eastofengland@nhs.net |
| Notify applications to:  | ivig@addenbrookes.nhs.uk (do not include patient data) |

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| Date of request (*DD/MM/YY*) |  Click here to enter a date. |
| Name of treating consultant | Click here to enter text. |
| Treating centre | Click here to enter text. |
| Contact details (email / phone) | Click here to enter text. |
| Name of requester (*if different*) | Click here to enter text. |
| Patient name (Surname, Forename) | Click here to enter text. |
| Date of Birth | Click here to enter text. |
| NHS number | Click here to enter text. |
| Do you have 2nd opinion support?(name, post, contact details) | Click here to enter text. |
| If known |
| Patient weight (kg) | Click Kg | **Dose determining weight (DDW) formula** |
| Gender | Choose an item. | Males: [(height(cm) – 154) x 0.9) + 50] = IBWFemales: [(height(cm) – 154) x 0.9) + 45.5] = IBW |
| Patient height (cm) |  Click cm | DDW = IBW + 0.4(ABW – IBW) |
| **Use Actual Body Weight if IBW >ABW, if <60kg, if <152cm** |
| **Clinical information** |
| Condition to be treated with Immunoglobulin | Click here to enter text. |
| Is this treatment commissioned or uncommissioned? | Click to choose from list |
| Relevant secondary diagnosis/diagnoses  | Click here to enter text. |
| Relevant clinical data / findings | Click here to enter text. |
| Does the treating consultant have previous experience using IVIG for this indication? | Choose an item. |
| What clinical criteria will the efficacy of immunoglobulin be assessed against? | Click here to enter text. |
| At which time point(s) would it be reasonable to assess efficacy? | Click here to enter text. |
| Urgency of request | Choose an item. |
| What other immunosuppressive medicines : |
| Are prescribed? | Click here to enter text. |
| Have been tried? | Click here to enter text. |
| Might be considered as an alternative? | Click here to enter text. |
| Is plasma exchange available? | Choose an item. |
| Has the patient received immunoglobulin treatment for: |
| this indication previously? | Click here to enter text. |
| any other indication previously? | Click here to enter text. |
| **What treatment is being applied for?** |
| Dose (g/kg) | Click here to enter text. |
| Over (x) days (*if applicable*) | Click here to enter text. |
| Frequency (*e.g. once, 6 weekly*) | Click here to enter text. |
| Duration (e.g. number of courses, months or years of treatment) | Click here to enter text. |
| **Supporting evidence (for all uncommissioned indications)** |
| Supporting evidence (attach to email) | Click here to enter text. |

Form created:

NHS England Commissioning Guideline for Immunoglobulins (2018) [link](https://www.england.nhs.uk/wp-content/uploads/2019/03/PSS9-Immunoglobulin-Commissioning-Guidance-CQUIN-1920.pdf)

By submitting this form the treating consultant agrees:

1. to provide clinical information as required by the East of England Immunoglobulin Assessment Panel for clinical approval to treat and for ongoing review of efficacy
2. to abide by treatment decisions made by the panel





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| **For use of EOEIAP / pharmacy department only** |
| Summary of panel recommendation |
| Name of EOEIAP member | Approval (✓) | Date | By (format):e.g. verbal / email / Epic record |
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| Rejection(s) – detail: |  |
| Further assessment / follow up: |  |