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Request: Patient Designated Plasma Protein Products

BOX 1: INFORMATION TO BE PROVIDED BY REQUESTING HOSPITAL

(Send initial, change and renewal requests and Plasma Protein Products Order to your local Canadian Blood Services Distribution Site)

Lead time: 2 Weeks. Note: This form must be used for initial requests of Eloctate and Alprolix or for renewal / changes to existing contracts. Once a contract number has been obtained subsequent orders can be sent in on the Plasma Protein Products Order form.

Section I: Requesting Hospital Details

Hospital Name: ______________________ Request Date: YYYY-MM-DD ________

Hospital Contact Person: ______________________ Contact # *(cell, pager, etc.)*: ________

Ship to (if different than ordering hospital/clinic): ______________________

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

Section II: Patient Information

New Patient: ☐

Year of Birth: YYYY

Existing Patient Change or Renewal: ☐

Patient #: ________

Contract #: ________

Reason for Change or Renewal: ________

Section III: Criteria

Eloctate ☐

- Up to 100 exposure days ☐
- Immune Tolerance Induction (ITI) ☐
- Other ☐ (provide rationale below)

Alprolix ☐

- < 18 years of Age ☐
- Other (provide rationale below) ☐

If criteria for **Eloctate or Alprolix** is identified as "Other" Medical approval will be required (approx. 30 days)

Rationale (Other): ______________________

Date of Expected Transition from Eloctate/Alprolix to new: YYYY-MM-DD

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

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

Duration in months:

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

Month of Next Pick Up: ________

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

Section V: Comments

SAMPLE

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BOX 2: CANADIAN BLOOD SERVICES USE ONLY: PHYSICIAN DECISION

(Signature and Name of Canadian Blood Services Physician only required for Category "Other" in Box 1)

Section VI: Product Request

If Medical decision was provided verbally: indicate decision and in comment section record as per Doctor (input doctors name) initial and date. Example: *as per Dr. Jane Doe LA 2018-07-27*

Approved ☐ Denied ☐

Comments: ____________________

Signature of Physician(s): ____________________

Review Date: YYYY-MM-DD

BOX 3: CANADIAN BLOOD SERVICES USE ONLY: COMMENTS AND CONTRACT INFORMATION

Section VII: Comments and Contract Information

Comments: ____________________

SAP Patient #: __________ **SAP Contract #:** __________

Entered by: Initials **Date:** YYYY-MM-DD

SAMPLE