Ontario

Ministry of Health and Long-Term Care

Ontario Public Drug Programs (OPDP)
Drug Programs Delivery Branch
5700 Yonge Street 3rd floor
Toronto ON M2M 4K5

Request for Myozyme®

Please fax completed form and/or any additional relevant information to 416 327–7526 or toll-free 1 866 811–9908; or send to the Exceptional Access Program (EAP), 5700 Yonge Street, 3rd floor, Toronto ON M2M 4K5.
For copies of this and other EAP forms, please visit http://www.health.gov.on.ca/en/pro/programs/drugs/eap_mn.aspx

The Executive Officer (EO) of Ontario Public Drug Programs considers requests for coverage of drug products not listed in the Ontario Drug Benefit Formulary under the Exceptional Access Program (EAP). This form is intended to facilitate requests for drugs considered under the EAP. The EO may request additional documentation to support the request. ***Please ensure that all appropriate information for each section is provided to avoid delays.***

Section 1 – Prescriber Information

First name | Initial | Last name

Type of Prescriber
☐ Physician ☐ Nurse practitioner ☐ Other ►

Mailing Address
Street no. | Street name

City | Postal code

Treatment Centre

Fax no. | Telephone no.

Section 2 – Patient Information

First name | Initial | Last name

Ontario Health Insurance Number

Gender ☐ Male ☐ Female

Body Weight (kg)

Date of birth *(yyyy/mm/dd)*

☐ **New request**

☐ **Renewal of existing EAP approval** *(specify EAP#)* _____ – _____

Section 3 – Drug, Dosage and Regimen

☐ Myozyme® (alglucosidase-alfa) 50 mg/ml

Regimen and Dosage

Section 4 – Clinical Information – New Request

☐ Confirmed Diagnosis of Hunter's Disease

Age at Diagnosis: _____

Please provide enzymology testing report AND mutation analysis report

Infantile / Early Onset Pompe Disease: *(require all 3 clinical features below to be eligible for reimbursement):*

☐ Onset of generalized weakness before 12 months of age
☐ Feeding difficulties resulting in failure to thrive
☐ Presence of significant cardiomyopathy

Ventilator Status:

Adult / Late Onset Pompe Disease:

☐ Provide **myometric confirmation** or **Medical Research Council (MRC) confirmation** for proximal and distal muscle;
AND/OR
☐ Provide **Spirometry Report** and details of respiratory function:

Provide details on current functional status

☐ Ambulatory ☐ Ambulatory with assistance ☐ Wheelchair outside the home
☐ Wheelchair inside the home ☐ Bedbound

Ventilator Status *(include status of c-pap or bi-pap use):*

Provide Eastern Cooperative Oncology Group (ECOG) Performance Status:

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Section 5 – Clinical Information – Renewal Request

Infantile / Early Onset Pompe Disease:

Ventilator Status: *(if patient on ventilator, please confirm if patient has been deteriorating after initiation of ventilatory support)*

Provide **Chest Radiograph, ECG, and Echocardiogram Reports** *(to determine cardiac function)*

Adult / Late Onset Pompe Disease:

Provide **Spirometry Report** and details of respiratory function

Ventilator Status *(include status of c-pap or bi-pap use):*

Provide details on current functional status

- ☐ Ambulatory
- ☐ Ambulatory with assistance
- ☐ Wheelchair outside the home
- ☐ Wheelchair inside the home
- ☐ Bedbound

Provide Eastern Cooperative Oncology Group (ECOG) Performance Status:

Section 6 – Current Medication Use and Co-Morbid Conditions

List of current medication use **and** document serious co-morbid conditions, if any

The information on this form is collected under the authority of the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3, Sched. A (PHIPA) and Section 13 of the *Ontario Drug Benefit Act*, R.S.O. 1990c.O.10 and will be used in accordance with PHIPA, as set out in the Ministry of Health and Long-Term Care "Statement of Information Practices", which may be accessed at www.health.gov.on.ca. If you have any questions about the collection or use of this information, call the Ontario Drug Programs Help Desk at 1 800 668–6641 or contact the Director, Drug Programs Delivery Branch, 5700 Yonge St., 3rd Floor, Toronto ON M2M 4K5.

Authorized prescriber *(print name)*	Authorized prescriber signature *(mandatory)*	Registration number	Date *(yyyy/mm/dd)*