Request for Immunomodulatory Therapy (IMT) for Non-infectious Ocular Inflammatory Disease (OID): Exceptional Access Program (EAP)

Canadian Uveitis Society

ORA Ontario Rheumatology Association

To avoid delays, please ensure that all appropriate information for each section is provided.

Section 1 – Physician Information

First Name	Initial	Last Name

Street #	Street Name

City	Postal Code

Fax	Telephone (Back Line)

Section 2 – Patient Information

First Name	Initial	Last Name

OHIP Number	

Gender ☐ Male ☐ Female	Current Weight (kg)

Date of Birth (DD/MM/YYYY)

Request Type ☐ New Request (complete sections 3, 4 & 5) ☐ Renewal Request (complete sections 3, 4 & 6)

Is the patient currently taking the drug requested below? ☐ Yes - Start Date (DD/MM/YYYY): ☐ No

EAP #

Section 3 – Drug, Dose and Regimen Requested

☐	**Mycophenolate Mofetil** (Cellcept®)	1000 – 1500 mg po bid, or up to 1200 mg/m2/day divided BID for patient <18 years
☐	**Infliximab** (Remicade®)	5-10 mg/kg IV at 0, 2, 6 weeks followed by maintenance therapy every 4-8 weeks
☐	**Adalimumab** (Humira®)	40 mg subcutaneous every 1-2 weeks; For patients <18 years: 20 mg for patients <30 kg, 40 mg for patients ≥30 kg
☐	**Rituximab** (Rituxan®)*	**Up to** 1000 mg IV on days 1 and 15 and 3rd infusion at 6-12 months
☐	Other (Specify dose, route and frequency of administration) :	

Dosage

Dosing Frequency

*Rituximab is not funded for maintenance therapy. For subsequent rituximab requests following the initial requests, patients will be considered upon experiencing subsequent deterioration of symptoms at least 6 months from the last dose of rituximab.

Section 4 – Clinical Information

1. Specify the type ocular inflammatory disease (OID) for which the drug product is being requested:

☐ Chronic Juvenile Idiopathic Arthritis (JIA) - associated uveitis
☐ Ocular inflammation associated with Behcet's disease
☐ Scleritis
☐ Uveitis
☐ Ocular mucous membrane pemphigoid
☐ Retinochoroidopathy
☐ Serpiginous choroidopathy
☐ Other (Specify):

Specify if disease is: ☐ Anterior ☐ Intermediate ☐ Posterior ☐ Pan-Uveitis

2. Immediately vision-threatening OID? ☐ No ☐ Yes - Provide consultation notes/letter from specialist in OIDs to confirm severity

3. The OID affects: ☐ Left eye ☐ Right eye ☐ Both eyes

4. Specify the type of ocular specialist overseeing this patient's treatment:

☐ Uveitis specialist ☐ Retinal specialist familiar with OIDs ☐ Pediatric ophthalmologist ☐ Other (Specify specialty):

Section 5 – Previous / Current Therapies

To avoid delays, provide details of ALL prior treatments with corticosteroids (include the route of administration) AND formulary immunosuppressants (e.g. methotrexate) or provide reasons why funded alternatives cannot be used.

Name of Drug (Specify drug name)	**Never prescribed**	**Route of administration** (e.g. oral/topical/SC/intravitreal/subtenon)	**Dose**	**Start Date** (DD/MM/YYYY)	**End Date** (DD/MM/YYYY)	**Response to therapy (e.g. efficacy, intolerance, etc.) / Contraindication and include reason for discontinuation**
☐ Corticosteroid:	☐					
☐ Methotrexate:	☐					
☐ Other:	☐					
☐ Other:	☐					
☐ Other:	☐					

Section 6 – Renewal Information

Check all that apply and provide recent consultation notes/letter with clinical update and details of treatment response:

☐ Improvement of vision ☐ Stability of vision ☐ Remission from/control of ocular inflammation

RITUXIMAB SPECIFICALLY, please check/complete all that apply and provide recent consultation notes/letter with clinical update:

☐ Experiencing deterioration of symptoms

Infusion Date (DD/MM/YYYY): Treatment response:

Infusion Date (DD/MM/YYYY): Treatment response:

Physician Signature (Mandatory)	CPSO Number	Date (DD/MM/YYYY)

Please fax the completed form and/or any additional relevant information to **416-327-0981** or toll free **1-866-811-9908**, or send to the Exceptional Access Program, 3rd floor, 5700 Yonge St, North York, Ontario, M2M 4K5. For copies of this form please visit: **CanadianUveitisSociety.com** or **http://ontariorheum.ca/drug-forms-and-codes/eap-forms**

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