Application for transferring reimbursement approval of patisiran (Onpattro®), vutrisiran (Amvuttra®) or inotersen (Tegsedi®)

For MMP Use Only	
Case Reference	*Date Received*

ALL SECTIONS OF THIS FORM MUST BE COMPLETED

Part 1: Patient Details

Name of patient:				
Date of birth:				
Address:				
GMS / DPS / PPS Number: (Please tick and insert number)	GMS	DPS	PPSN	Number:

Part 2: Prescriber Details

Name of Consultant:	
Medical Council Number:	
Speciality of Prescribing Consultant:	Neurology ☐ Cardiology ☐ Other (Please specify) _____
Contact Details:	Hospital:
	Address:
	Telephone:
	Email:

Please refer to the *HSE-Managed Access Protocol-Medicines used in hereditary transthyretin amyloidosis in adult patients with stage 1 or stage 2 polyneuropathy* when completing this form

Part 3: Patient details for switching medication

1.The patient currently has reimbursement approval for:

Inotersen (Tegsedi®) ☐ Patisiran (Onpattro®) ☐ Vutrisiran (Amvuttra®) ☐

Please confirm the proposed **discontinuation** date: ☐

2. I wish to apply to transfer reimbursement approval to:

Inotersen (Tegsedi®) ☐ Patisiran (Onpattro®) ☐ Vutrisiran (Amvuttra®) ☐

Please confirm the proposed **initiation** date: ☐

Please indicate the patient's **current** stage of polyneuropathy disability using the table below and date of measurement:

PND score	Score description	*FAP stage	Stage description	Choose one:
0	No impairment	0	No symptoms	☐
I	Sensory disturbances, preserved walking capabilities	1	Unimpaired ambulation, mostly mild sensory and motor neuropathy in the lower limbs	☐
II	Impaired walking capabilities but ability to walk without stick or crutches	2	Assistance with ambulation needed; mostly moderate impairment progression to the lower limbs, upper limbs and trunk	☐
IIIA	Walking only with the help of 1 stick or crutch	2	Assistance with ambulation needed; mostly moderate impairment progression to the lower limbs, upper limbs and trunk	☐
IIIB	Walking only with the help of 2 sticks or crutches	2	Assistance with ambulation needed; mostly moderate impairment progression to the lower limbs, upper limbs and trunk	☐
IV	Confined to a wheelchair or bedridden	3	Wheel-chair bound or bedridden; severe sensory and motor neuropathy of all limbs	☐
FAP: Familial amyloidotic polyneuropathy, PND: Polyneuropathy disability * hATTR amyloidosis with polyneuropathy was formerly known as FAP			**Date of assessment**	DD/MM/YYYY

Part 4: Dosing Information (please complete if switching to patisiran or vutrisiran)

State the proposed location of administration (hospital or site name)

_____

For patisiran applications please provide:

- Patient weight
- Proposed dose of patisiran

Additional space for supporting information

Data Protection Notice

- The information on this form will be used by the Health Service Executive (HSE) to assess the suitability of the items listed to be provided under Section 20 of the Health (Pricing and Supply of Medical Goods) Act 2013.
- Details of prescription items dispensed to the named person may be notified to the HSE by the dispensing pharmacist to ensure that the named person receives the items required.
- The named person may access information relating to themselves only, on prescription claims processed in their name by the HSE.
- We may share information with the Department of Health, healthcare practitioners and other healthcare bodies.
- We may also disclose information to other parties if the law requires us to do so.
- The PCRS privacy statement can be located at www.pcrs.ie.

Completed forms should be returned to:

Scan the completed form and return via a secure email (e.g. HSE email or healthmail) to: mmp@hse.ie

Authorisation of Request

Signature of Consultant	
Institution	