# Glassia Request - Patient Designated Plasma Protein and Related Product

**INFORMATION TO BE PROVIDED BY REQUESTING CLINIC/PRESCRIBER**

- This form must be used for initial requests, renewals and changes related to **Glassia ONLY**. For requests involving other patient designated plasma protein and related products, please refer to the appropriate form available on our website: Hospital Services > Inventory Ordering > Submitting product orders.
- Request forms must be sent to SAPPRPRequests@blood.ca or to your **local Canadian Blood Services Distribution Site** at least 2 weeks before product is required - review may take longer if requesting access outside of listed criteria (i.e., exceptional access).
- If approved, a **contract number** will be assigned which must be referenced on subsequent orders using the Order Form for Plasma Protein and Related Products Requiring Contracts or through the Online Ordering Portal.

**Section I: Requesting Clinic Details and Patient Information** (complete for all request types).
**Unless this is an emergency request, by completing and submitting this form, you agree that your patient has been provided the Privacy Notice for Patient Designated Plasma Protein and Related Products.**

**Respirology Clinic Information**
Canadian Blood Services customer # if known:

Request Date (YYYY-MM-DD):

Requesting Respirology Clinic Name:

Ship to Hospital/Transfusion Medicine Lab (Blood Bank)/Location:

Clinic Contact 1*:

Email: Phone #: Fax#:

Clinic Contact 2*:

Email: Phone #: Fax#:

Ordering prescriber:

Email: Phone #: Fax#:

***Contract Notification will go to the Clinic Contact(s) Email/Fax#.**

**Patient Information**

Last Name: First Name:

Date of Birth (YYYY-MM-DD): Sex (M/F):

Height (cm): Weight (kg):

Provincial/Territorial Health Card Number:

Province/Territory of Residence:

**Section II: Request Type**

☐ New Patient (proceed to section III) ☐ Renewal (includes changes)

| Canadian Blood Services Patient # | Canadian Blood Services Contract # |
|---|---|

# Glassia Request - Patient Designated Plasma Protein and Related Product

Canadian Blood Services — BLOOD PLASMA STEM CELLS ORGANS & TISSUES

**Section III: Product and Criteria**

**Diagnosis:**

**Glassia (alpha-1 proteinase inhibitor)**

| Glassia may be requested for adult patients that meet ALL of the following criteria*: | Supporting Information (**#** required values) | |
|---|---|---|
| ☐ Respirologist has confirmed the diagnosis of severe alpha-1 proteinase inhibitor (A1-PI) deficiency and clinical evidence of emphysema and indicated that patient would benefit from treatment with A1-PI product<br>☐ A1-PI deficiency, defined as serum A1-PI levels < 57 mg/dL before start of the treatment<br>☐ Clinical evidence of obstruction (FEV1 <80%)<br>☐ Nonsmoker for at least 6 months<br>☐ Has not received a lung transplant<br>*If patient does not meet listing criteria an exceptional access review will be required. **More information below.** | Baseline serum A1-PI level[#]<br><br>**(i.e., A1-PI level at diagnosis, prior to initiation of augmentation therapy)** | ☐ mg/dL<br>☐ g/L<br>☐ µmol/L |
| | FEV1 (%)[#] | |

**Current Therapy or ☐ N/A**

Please specify the patient's current A1-PI augmentation therapy, if applicable, and all other prescribed therapies for managing the patient's pulmonary disorder(s), including bronchodilators, vaccines, oxygen therapy, smoking cessation, pulmonary rehabilitation, and other treatments.

| Product Name | Dose | Route of Administration | Frequency of Administration | Indication |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**New Requested Therapy or ☐ Same as Current Therapy**

| Product Name | Dose | Route of Administration | Frequency of Administration | Indication |
|---|---|---|---|---|
| | | | | |

**Other Supporting Information (including rationale for change or initiation of therapy):**

**Exceptional access review:** Required for patients that do not meet ALL the listing criteria. The case will be assessed by Canadian Blood Services to determine if there is a compelling clinical rationale that justifies a funder review. If warranted, the case will be submitted to the relevant jurisdiction for a funding decision.

Please provide a clinical rationale supporting the need for augmentation therapy with Glassia in this patient. This may include objective evidence (e.g., literature, case studies, clinical findings) demonstrating the potential clinical benefits of Glassia despite not meeting the approved criteria. Demonstrate how Glassia offers superior outcomes and addresses an unmet medical need and why an exception to the criteria should be considered.

**If this is a renewal of a previously approved exceptional access request**, please provide objective evidence of continued benefit and need for Glassia for this patient.

# Glassia Request - Patient Designated Plasma Protein and Related Product

| **Exceptional Access Review Information:** |
|---|
| |

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

Contracts will be created up to a maximum of 12 months, A renewal request will be required every 12 months

| **Vial Size** | **Total Contract Quantity** | **Pick Up Quantity** | **Frequency of Pick Up** (e.g., every 3 months) | **Duration of Contract** (max 12 months) |
|---|---|---|---|---|
| 1000mg / 50 ml Vial | | | | |
| | | | | |
| | | | | |
| | | | | |

| | | |
|---|---|---|
| Date of next product order (please comment if less than 1 week): | | Comments (please include when next dose is due for STAT requests): |
| Expiry date of approved contract (optional to fill out for records following CBS notification): | | |

**Section V: Urgent Medical Review and SAP Information (CBS Use Only)**

The on-call medical officer can be contacted after hours to review urgent requests for **patients that meet listing criteria**. Exceptional access reviews cannot be completed by the on-call medical officer and should be sent to the PPRP Formulary team for regular review. Please forward the request form with all documentation of medical review to SAPPRPRequests@blood.ca.

Decision of urgent medical officer review: ☐ Approve 30-day supply (specify amount below) ☐ Deny

Comments:

If medical review was obtained verbally, indicate results of review in comment section above. Include: as per (physician name), initial and date (e.g., as per Dr. Jane Doe, LA 2019-07-27)

| SAP Patient #: | SAP Contract #: | Completed/Entered by and date: |
|---|---|---|
| | | |