PATIENT DETAILS	*Affix patient Addressograph if available
SURNAME: _____	FIRSTNAME(S): _____
DATE OF BIRTH: _____/_____/_____	MRN: _____

NDMS Multiple Sclerosis Patient Eligibility Form Alemtuzumab (Lemtrada®)

Form must be completed in full and saved securely in the patient's medical record for audit purposes only

TREATMENT	HSE APPROVED INDICATION	ICD10	Protocol Code
Alemtuzumab (Lemtrada®)	Alemtuzumab (Lemtrada®) is indicated as a single disease modifying therapy in adults with highly active relapsing remitting multiple sclerosis (RRMS) for the following patient groups: • Patients with highly active disease despite a full and adequate course of treatment with at least one disease modifying therapy (DMT) OR • Patients with rapidly evolving severe relapsing remitting multiple sclerosis defined by 2 or more disabling relapses in one year, and with 1 or more Gadolinium enhancing lesions on brain MRI or a significant increase in T2 lesion load as compared to a previous recent MRI.	**G35**	**MS100**

ELIGIBILITY	YES	NO
Indication as per Protocol MS100		
Eligibility criteria in Protocol MS100 have been satisfied		
EXCLUSIONS	**YES**	**NO**
All exclusion criteria laid out in protocol MS100 have been considered		

PREVIOUS MEDICATION(S) FOR MULTIPLE SCLEROSIS			
Name of Medicine (in order of use; 1. = first line etc.)	Reason for change in treatment (please tick)		
	Adverse Event	Loss of Response	Other Reason
1.			
2.			
3.			
4.			
5.			
SECTION D PRESCRIBER DETAILS			
Prescriber Name			
Medical Registration Number			
ELIGIBILITY FORM COMPLETED BY			
Name			
Date			