Liposomal DOXOrubicin - HIV - positive Kaposi's Sarcoma

(This form must be completed before the first dose is dispensed.)
1. Patient Profile

- Surname: 
- Given Name: 
- OHIN: 
- Chart Number: 
- Postal Code: 
- Height (cm): 
- Weight (kg): 
- BSA (m²): 
- Gender: Male, Female, Other 
- Date of Birth: Day Month Year 
- Site: 
- Attending Physician (MRP - Most Responsible Physician): 

Requested Prior Approval: Yes No 
Patient on Clinical Trial: Yes No 
Other (specify): 
Specify Arm: Standard of care arm, Experimental arm, Blinded / Unknown

Request prior approval for enrolment

- Justification for Funding 

2. Eligibility Criteria

The patient must meet the following criteria:

a. Patient has HIV-positive Kaposi’s sarcoma Yes
b. Patient has:  
- visceral Kaposi’s sarcoma  
- progressive disease despite prior therapy with vinblastine or interferon

c. Patient has:  
- signs of peripheral neuropathy or is believed to be at high risk of neuropathy  
- other medical condition that makes it inappropriate to use standard combination chemotherapy.  
Please specify the nature of the condition:


d. ECOG performance status is 0-2:

3. Funded Dose

- Liposomal doxorubicin is 20 mg/m^2 every 2 weeks

4. Supporting Documents

To ensure reimbursement of your claim, both the completed enrolment form and a copy of the required documentation (where applicable) must be submitted through CCO e-Claims.

Signature of Attending Physician (MRP-Most Responsible Physician): .................................................

................................................................. Day  Month  Year