Pamidronate for Plasma Cell Myeloma

(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. The patient has plasma cell myeloma ☐ Yes
b. The patient has no evidence of bone disease

3. Funded Dose

- 90mg IV q4 weeks

4. Notes

a. It is recommended that patients be treated for a minimum of 2 years.

b. After 2 years of bisphosphonate treatment:
   - Patients who have achieved remission and are in stable plateau phase off treatment should consider discontinuing the use of bisphosphonates.
   - Patients who still require active treatment for their myeloma should continue on bisphosphonates, but may consider having the frequency decreased to every 3 months if on pamidronate.

c. Patients whose myeloma becomes active following an initial response should resume monthly bisphosphonate therapy while on active treatment.

5. 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