

Highly efficacious DMTs (Natalizumab, Ocrelizumab, Siponimod) imbursement criteria: Checklist

(This checklist is needed when a patient is sent for a highly efficacious DMT)

DMT requested:

- Natalizumab (Tysabri[®])
 Ocrelizumab (Ocrevus[®])
 Siponimod (Mayzent[®])

Patient's name: Age: years.

National ID:

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MS phenotype:

- RRMS:** Active. Highly active. Aggressive.
- Transitioning:** With activity. Without activity.
- SPMS:** Active. Inactive.
- PPMS:** Active. Inactive.

Current EDSS:

Visual:	Brainstem:	Pyramidal:	Cerebellar:
Sensory:	Cerebral:	Bowel and bladder:	
Ambulation:			

Previous EDSS if present:

Date:/...../..... Score:

Onset of MS disease: OR Disease duration:

Timeline

Previous DMTs if any:

Name	Dose	Start date	End date	Compliance	Cause of stoppage

Evidence of activity (if any)

A) Clinical activity: Details of last two clinical relapses:

Date	Domains involved	Hospitalization	Severity	Recovery	Time to recovery
...../...../.....	<input type="radio"/> Visual				
...../...../.....					

B) Radiological activity: Details of last MRI:

Date:/...../..... Examined parts: Brain. Cervical cord. Dorsal cord.

T2/FLAIR lesions	Lesion number/brain load: Sites involved: <input type="radio"/> Periventricular. <input type="radio"/> Cortical/Juxtacortical. <input type="radio"/> Infratentorial. <input type="radio"/> Spinal: <input type="radio"/> Cervical: <input type="radio"/> Single. <input type="radio"/> Multiple. <input type="radio"/> Dorsal: <input type="radio"/> Single. <input type="radio"/> Multiple.
T1 blackholes	<input type="radio"/> Yes. <input type="radio"/> No.
Evidence of radiological activity/progression	<input type="radio"/> Yes. <input type="radio"/> No. If yes, specify: <input type="radio"/> New/enlarging T2/FLAIR lesions. Number: <input type="radio"/> Gad/enhancing lesions. Number: <input type="radio"/> Brain atrophy. <input type="radio"/> Cord atrophy.

Evidence of progression (if any): Yes. No [This section is to be filled only for Mayzent®]

If Yes: Duration of progression: Three months Six months Other:

Progression at:	Baseline	Follow-up	Progression (at least one is needed)
<input type="radio"/> EDSS	Date:/..../..... Score:	Date:/..../..... Score:	<input type="radio"/> 0.5 point <input type="radio"/> 1 point <input type="radio"/> 1.5points <input type="radio"/> ≥2 points
<input type="radio"/> SDMT	Date:/..../..... Score:	Date:/..../..... Score:	<input type="radio"/> ≥10%: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ≥4 points: <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> 9HPT	Date:/..../..... Score:	Date:/..../..... Score:	<input type="radio"/> ≥20%: <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> T25FWT	Date:/..../..... Score:	Date:/..../..... Score:	<input type="radio"/> ≥20%: <input type="radio"/> Yes <input type="radio"/> No

Domains with evidence of progression:

Cognition Pyramidal Cerebellar Ambulation Bowel/bladder Visual Brainstem Sensory

Lab investigations

Oligoclonal bands:

Date:/...../.....
Result: <input type="radio"/> Positive <input type="radio"/> Negative. Number of bands (if applicable): IgG index:

JC virus antibody: (Mandatory for all RRMS cases requested to receive Tysabri® or Ocrevus®).

CYP2C9 genotype: *1/*1 *1/*2 *2/*2 *1/*3 *2/*3 *3/*3.

(Mandatory for all cases requested to receive Mayzent®).

Doctor's signature and date