SCOTTISH TDM SERVICE - ADALIMUMAB REQUEST

Please complete each question either by ticking a box or completing the open text box with a comment. It is a requirement of the NSD funding that this information is collated and audits on effectiveness undertaken.

Please forward completed form and sample to: -

Dr Peter Galloway, Consultant Clinical Biochemist, Laboratory Building, QEUH, G51 4TF

Patient Label

DATE OF TEST

____/_____/_____

RESPONSIBLE CLINICIAN/NURSE

_____

HOSPITAL

_____

1) PRIMARY INIDICATION FOR DRUG PRESCRIPTION

CROHNS DISEASE	□	RHEUMATOID ARTHRITIS	□
ULCERATIVE COLITIS	□	ANKYLOSING SPONDYLITIS	□
OTHER GASTROINTESTINAL	□	PSORIATIC ARTHRITIS	□
		JUVENILE IDIOPATHIC ARTHRITIS	□
UVEITIS	□	OTHER RHEUMATOLOGICAL	□

2) ADALIMUMAB BRAND

HUMIRA	□	IMRALDI	□
AMGEVITA	□	OTHER	

3) DRUG DOSE

40MG □ 80MG □ 20MG □

OTHER

4) DOSING FREQUENCY

EVERY 2 WEEKS	□	EVERY WEEK	□
EVERY 3 WEEKS	□	EVERY 4 WEEKS	□

OTHER

5) CONCOMITANT IMMUNOSUPPRESSION

THIOPURINE	□	METHOTREXATE	□
LEFLUNOMIDE	□	SULPHASALAZINE	□
NONE	□		

OTHER

6) INDICATION FOR TEST

PRIMARY NON-RESPONSE	□	END OF INDUCTION (WEEK 12-14) (RESPONDING TO TREATMENT)	□
SECONDARY LOSS OF RESPONSE	□	PLANNED TREATMENT REVIEW (RESPONDING TO TREATMENT)	□
POST DOSE-ADJUSTMENT	□		

OTHER

7) ADDITIONAL INFORMATION

Please use this free text box to supply further relevant information