PHARMACARE SPECIAL AUTHORITY REQUEST

RITUXIMAB FOR GRANULOMATOSIS WITH POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

HLTH 5393 Rev. 2013/05/07

☐ **INITIAL (1 course)** **Complete sections 1–5, 7**

☐ **RENEWAL (1 course)** **Complete sections 1–4, 6–7**

For up to date criteria and forms, please check: http://www.health.gov.bc.ca/pharmacare/prescribe.html

Fax requests to 1 800 609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4

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Should approval be granted for this Special Authority request, PharmaCare's authorization is solely for the purpose of providing prescription benefit for the cost of the requested medication. PharmaCare makes no representation about the suitability of the requested medication for the patient's, or any other, medical condition or problem.

Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.

SECTION 1 – PRESCRIBER INFORMATION

Prescriber's Name and Mailing Address ☐ Mail Confirmation	
☐ College ID **OR** ☐ MSP Number	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE ➞	Prescriber's Fax Number

SECTION 2 – PATIENT INFORMATION

Patient (Family) Name	
Patient (Given) Name(s)	
Date of Birth (yyyy / mm / dd)	Date of Application (yyyy / mm / dd)
CRITICAL FOR PROCESSING ➞	Personal Health Number (PHN)

SECTION 3 – CURRENT STATUS

Diagnosis requiring use: for the induction of remission in patients with severely active: ☐ granulomatosis with polyangiitis OR ☐ microscopic polyangiitis	ESR OR CRP
Name and dosing regimen of current corticosteroid therapy (or please clarify if none)	
Physician overall assessment of current disease activity; on a scale of 0 – 10, where 0 = remission and 10 = severe active disease.	☐ Current BVAS (Birmingham Vasculitis Activity Score) completed by specialist and attached

SECTION 4 – DOSING REGIMEN REQUESTED

☐ rituximab, 375 mg/m2 weekly x 4 weeks; anticipated dose per infusion: ____________

☐ Patient's current Body Surface Area (BSA) required: ____________

OR ☐ other (e.g., rituximab, 1000 mg at 0 and 2 weeks) - specify: ____________

Anticipated maintenance therapy

☐ azathioprine ☐ other (specify)

☐ methotrexate ☐ none

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE (YYYY / MM / DD)	DURATION OF APPROVAL

RITUXIMAB FOR GRANULOMATOSIS WITH POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

Patient (Family) Name	Patient (Given) Name(s)	Personal Health Number (PHN)

SECTION 5 – INITIAL COVERAGE INFORMATION

☐ Copy of ANCA report attached

Details of past cyclophosphamide trial or contraindications to use:	Specific Details
☐ Failure of a minimum of six IV pulses of cyclophosphamide ☐ Failure of at least a three month trial of oral cyclophosphamide ☐ Severe intolerance or allergy to cyclophosphamide or worsening despite current cyclophosphamide therapy (provide details) ☐ A cumulative lifetime dose of at least 25 grams of cyclophosphamide has been administered ☐ Cyclophosphamide is contraindicated. Please provide details regarding all patient specific contraindications, **as well as** other previously tried therapies for this condition (and response).	

SECTION 6 – RENEWAL INFORMATION

Anticipated Retreatment Date (approximate, if exact date not known)	Date of Most Recent Rituximab Dose

Benefits Seen on Rituximab, and Specific Details of Need for Retreatment

SECTION 7 – ADDITIONAL INFORMATION AS APPLICABLE

Please submit additional supporting information that would be of assistance to PharmaCare in making a decision regarding coverage (e.g. biopsy reports, details of past hospital admissions, etc.)

Personal information on this form is collected for the operations of the Ministry of Health. The Ministry will use the information in the decision to provide PharmaCare benefits for the medication requested, and for implementation, monitoring and evaluation of this and other Ministry programs, and for the management and planning of the health system generally. Personal information will be used and disclosed in accordance with the privacy protection provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I have discussed with the patient the purpose of the release of the patient's information to PharmaCare to obtain Special Authority for prescription benefit and for the purposes set out above.

Nephrologist / Respirologist / Rheumatologist Signature (Mandatory)

PharmaCare may request additional documentation to support this Special Authority request.
Potential coverage is still subject to patient eligibility, annual deductibles, and the Low Cost Alternative pricing program (if applicable).