



INITIAL (1 course) Complete sections 1-5

RENEWAL (1 course) Complete sections 1-4, 6

For up to date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority

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

This facsimile is Doctor-Patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested medication is, or is not, suitable for any specific patient or condition.

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

Form for Section 1: Prescriber's Name and Mailing Address, Mail Confirmation, College ID, MSP Number, Phone Number, Prescriber's Fax Number, and Critical For a Timely Response indicator.

SECTION 2 - PATIENT INFORMATION

Form for Section 2: Patient (Family) Name, Patient (Given) Name(s), Date of Birth, Date of Application, Personal Health Number (PHN), and Critical For Processing indicator.

SECTION 3 - CURRENT STATUS

Form for Section 3: Diagnosis requiring use, ESR/CRP, Name and dosing regimen of current corticosteroid therapy, Physician overall assessment of current disease activity, and Current BVAS.

SECTION 4 - DOSING REGIMEN REQUESTED FOR RITUXIMAB 9901-0156

Form for Section 4: Dosing regimen (rituximab 375 mg/m2 weekly x 4 weeks or other), Patient's current Body Surface Area (BSA) required, and Anticipated maintenance therapy (azathioprine, methotrexate, or other).

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

Table for Pharmacist Use Only with columns: STATUS, EFFECTIVE DATE (YYYY / MM / DD), and DURATION OF APPROVAL.

RITUXIMAB FOR GRANULOMATOSIS WITH POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

Patient (Family) Name	Patient (Given) Name(s)	Personal Health Number (PHN)
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SECTION 5 – INITIAL COVERAGE INFORMATION

<input type="checkbox"/> Copy of ANCA report attached	Year of Diagnosis:
Details of past cyclophosphamide trial or contraindications to use: <input type="checkbox"/> Failure of a minimum of six IV pulses of cyclophosphamide <input type="checkbox"/> Failure of at least a three month trial of oral cyclophosphamide <input type="checkbox"/> Severe intolerance or allergy to cyclophosphamide or worsening despite current cyclophosphamide therapy (provide details) <input type="checkbox"/> A cumulative lifetime dose of at least 25 grams of cyclophosphamide has been administered <input type="checkbox"/> Cyclophosphamide is contraindicated. Please provide details regarding all patient specific contraindications, as well as other previously tried therapies for this condition (and response).	Specific Details

ADDITIONAL INFORMATION REQUIRED

Details regarding initial presentation and course of illness
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SECTION 6 – RENEWAL INFORMATION

Anticipated Retreatment Date (approximate, if exact date not known)	Date of Most Recent Rituximab Dose	Month and Year Rituximab Started
Benefits Seen on Rituximab, and Specific Details of Need for Retreatment		

Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* and *Freedom of Information and Protection of Privacy Act*. It will not be disclosed to any persons without the patient's consent. The information you provide will be relevant to and used solely to (a) provide PharmaCare benefits for the medication requested, (b) to implement, monitor and evaluate this and other Ministry programs, and (c) to manage and plan for the health system generally. If you have any questions about the collection or use 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 that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.

Nephrologist / Respirologist / Rheumatologist Signature (Mandatory)

PharmaCare may request additional documentation to support this Special Authority request.

Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.