



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 you have received this fax in error, please write "MIS-DIRECTED" across the front of the form and fax toll-free to 1 800 609-4884, then destroy the pages received in error.

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

NAME AND MAILING ADDRESS		<input type="checkbox"/> MAIL CONFIRMATION
<input type="checkbox"/> COLLEGE ID OR <input type="checkbox"/> 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 - MEDICATION DETAIL INFORMATION

<input type="checkbox"/> INITIAL REQUEST	<input type="checkbox"/> RENEWAL	DURATION REQUESTED (APPROVAL DURATION UP TO 6 MONTHS) _____ month(s)	DOSE REQUESTED <input type="checkbox"/> 300mcg <input type="checkbox"/> 480mcg
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SECTION 4 - INDICATION

4.1	<input type="checkbox"/> Post-BMT to stimulate bone marrow engraftment (start greater than or equal to d+1) <input type="checkbox"/> Post-BMT for rescue of failure to engraft (start greater than or equal to d+14) <input type="checkbox"/> Cancer patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy. Date of BMT: _____
4.2	<input type="checkbox"/> For rescue of prolonged febrile neutropenia following chemotherapy (adult febrile neutropenia: ANC < 1 x 10 ⁹ /L (and expected to further decline) AND temperature taken orally ≥ 38.3°C OR ≥ 38°C for ≥ 1 hour) Current ANC: _____ Date: _____
4.3	<input type="checkbox"/> For prevention of neutropenia which interferes with delivery of standard doses of greater than or equal to 2nd CYCLE of adjuvant AND potentially CURATIVE chemotherapy regimen
4.4	For patients with the following benign disorders: <input type="checkbox"/> chronic benign cyclical neutropenia <input type="checkbox"/> myelodysplastic disorders or aplastic anemia awaiting bone marrow transplantation
<p>Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the <i>British Columbia Pharmaceutical Services Act</i> and <i>Freedom of Information and Protection of Privacy Act</i>. 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.</p> <p>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.</p> <p>_____ Prescriber's Signature (Mandatory)</p>	

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.

PHARMACARE USE ONLY

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