BRITISH COLUMBIA | Ministry of Health

PHARMACARE
BIOSIMILARS INITIATIVE SUPPORT: RITUXIMAB PATIENT LIST REQUEST

HLTH 5842 2020/06/18

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

Prescribers can request a list of patients (for whom they have prescribed any of the medications below) to assist with biosimilar switching discussions.

A patient list will be returned to you within 14 days by fax. This list includes the first and last names of patients who have filled a prescription within the last 9 months for the drugs selected below, where you are the prescriber listed; no specific medication information will be provided.

Not all of the identified patients may be candidates for switching. This information is provided to assist you in identifying patients who may benefit from switching to a biosimilar.

SECTION 1 – SPECIALIST INFORMATION

MUST BE **FULLY COMPLETED** FOR PROCESSING

Specialist Full Legal Name	CPSBC License Number (Not MSP Number)
Specialist Mailing Address	
Specialist Fax Number	Specialist Phone Number

SECTION 2 – INFORMATION REQUESTED

Which best describes your practice?	Medication prescribed:
◯ Rheumatologist ◯ Neurologist ◯ Internal Medicine Specialist ◯ Other Specialist (please specify) _____	☐ Rituxan®

SECTION 3 – SPECIALIST SIGNATURE

Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the British Columbia *Pharmaceutical Services Act* 22 (1) (a) and *Freedom of Information and Protection of Privacy Act* 26 (a), (c) and (e). The information you provide will be relevant to and used solely to (a) provide the service 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, contact Health Insurance BC at 1-604-683-7151 or toll free at 1-800-663-7100 or by mail at PO Box 9140 Stn Prov Govt, Victoria BC V8W 9E5 and ask to consult a pharmacist concerning this process.

_____
Specialist's Signature (Mandatory)

_____
Date of Signature

PHARMACARE USE ONLY

STATUS

All fields on this form must be completed. Forms with missing information will be returned for completion.

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.

Print

Clear Form