BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

RITUXIMAB FOR GRANULOMATOSIS WITH POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

HLTH 5393 Rev. 2021/07/26

◯ **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 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

Prescriber's Name and Mailing Address	
College ID (use ONLY College ID 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

BIOSIMILAR RITUXIMAB: 9901-0348

Diagnosis requiring use: for the induction of remission in patients with severely active: ◯ granulomatosis with polyangiitis OR ◯ microscopic polyangiitis	☐ **Attached**: Current BVAS (Birmingham Vasculitis Activity Score) completed by specialist		
Prednisone Dose	Physician global assessment of ***inflammation*** (scale of 0 – 10, 0 = none, 10 = severe active disease)	ESR or CRP	**Current Weight in KG** - *Required for:* - initial request - renewal if significantly changed

LIST ALL CURRENT RELEVANT MEDICATIONS

Drug	Dose	Frequency	Drug	Dose	Frequency

SECTION 4 – BRAND AND DOSING REGIMEN REQUESTED FOR RITUXIMAB

◯ Ruxience® ◯ Truxima® ◯ Riximyo®

◯ 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, or 500 mg or 1000 mg every 6 month maintenance dosing)

specify: _____

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

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

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

SECTION 5 – INITIAL COVERAGE INFORMATION

5A) BACKGROUND INFORMATION

Date of Diagnosis (MM/YYYY)	ANCA Testing Results	Level at Presentation: ESR or CRP

How was the diagnosis of GPA/MPA established? (Please list biopsy results and results of other significant investigations)

Severity at Initial Presentation

◯ mild ◯ moderate ◯ severe ◯ critical (e.g. ICU/ventilation)

Areas of Involvement

☐ constitutional symptoms ☐ upper respiratory (ENT) ☐ lower respiratory ☐ musculoskeletal
☐ cutaneous ☐ cardiovascular ☐ renal ☐ other _____
☐ mucous membranes ☐ gastrointestinal ☐ nervous system ☐ other _____

Provide details of initial presentation:

5B) CYCLOPHOSPHAMIDE TRIAL If cyclophosphamide has been tried and can no longer be used complete 5B, if cyclophosphamide cannot be used complete 5C.

Further Cyclophosphamide use is contraindicated

☐ treatment failure (induction not successful)
☐ flare after prior induction with cyclophosphamide
☐ severe intolerance or allergy
☐ other (provide details) _____

Details of prior cyclophosphamide use:

☐ at least six IV pulses of cyclophosphamide
☐ at least a three month trial of oral cyclophosphamide
☐ a cumulative lifetime dose of at least 25 gm of cyclophosphamide
☐ other (provide details) _____

5C) CONTRAINDICATION(S) TO CYCLOPHOSPHAMIDE (provide details):

5D) IF OTHER TREATMENTS TRIED, PLEASE PROVIDE DETAILS:

Treatment Used	Starting Date	Duration of Use	Details of Trial and Response

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.

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