BRITISH COLUMBIA | Ministry of Health

*PHARMACARE SPECIAL AUTHORITY REQUEST*

# RITUXIMAB FOR GRANULOMATOSIS WITH POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

HLTH 5393 Rev. 2018/12/03

☐ **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**



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 ☐ 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

**RITUXIMAB: 9901-0156**

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 FOR RITUXIMAB

☐ 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 |
|---|---|---|
| | | |

HLTH 5393

# 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 | Year of Diagnosis: |
| Details of past cyclophosphamide trial or contraindications to use:<br>☐ Failure of a minimum of six IV pulses of cyclophosphamide<br>☐ Failure of at least a three month trial of oral cyclophosphamide<br>☐ Severe intolerance or allergy to cyclophosphamide or worsening despite current cyclophosphamide therapy (provide details)<br>☐ A cumulative lifetime dose of at least 25 grams of cyclophosphamide has been administered<br>☐ 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 |
|---|
| |

## 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.***

PRINT RESET