BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

FILGRASTIM (GRASTOFIL TYPE)

HLTH 5470 Rev. 2018/10/11

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 ☐ 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 – MEDICATION DETAIL INFORMATION

GRASTOFIL: 9901-0277

☐ INITIAL REQUEST ☐ RENEWAL

DURATION REQUESTED (APPROVAL DURATION UP TO 6 MONTHS)

_____ month(s)

DOSE REQUESTED

☐ 300mcg ☐ 480mcg

SECTION 4 – INDICATION

4.1

☐ Post-BMT to stimulate bone marrow engraftment (start greater than or equal to d+1)

☐ Post-BMT for rescue of failure to engraft (start greater than or equal to d+14)

☐ Cancer patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy. Date of BMT: _____

4.2

☐ 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

☐ For **PRIMARY** prophylaxis of febrile neutropenia in cancer patients receiving potentially **CURATIVE** myelosuppressive chemotherapy regimens, where the risk of febrile neutropenia is **≥ 20%**

☐ For **SECONDARY** prophylaxis of febrile neutropenia in cancer patients receiving potentially **CURATIVE** myelosuppressive chemotherapy

4.4

For patients with the following benign disorders:

☐ chronic benign cyclical neutropenia

☐ myelodysplastic disorders or aplastic anemia awaiting bone marrow transplantation

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.

_____

Prescriber's 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.

PHARMACARE USE ONLY

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

PRINT CLEAR FORM