BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

RITUXIMAB FOR AUTOIMMUNE CONDITIONS
INITIAL / RENEWAL REQUEST

HLTH 5848 Rev. 2023/10/24

◯ **INITIAL**
Complete sections 1 – 6, and 8 if applicable

◯ **RENEWAL**
Complete sections 1 – 3, 6 – 7, and 8 if applicable

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 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.

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

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 – PRESCRIBING SPECIALIST'S INFORMATION

Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Prescribing Specialist'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 – BIOSIMILAR RITUXIMAB

9901-0348

◯ rituximab 1000 mg at 0 and 2 weeks ◯ rituximab 100 mg weekly x 4 weeks

◯ rituximab 375 mg/m^2 weekly x 4 weeks; provide the anticipated dose per infusion. Round up or down to nearest whole vial: _____ 00 mg
(PharmaCare does not provide coverage for use of partial vials.)

☐ Patient's current Body Surface Area (BSA) required for mg/m^2 dosing: _____

◯ Other dose/frequency requested: _____

SECTION 4 – DIAGNOSIS / CLINICAL INFORMATION

Attach any clinical notes, consultations, laboratory and test results (e.g., radiology, complete blood count, serology, genetic testing results, etc.) that supports the diagnosis.

Diagnosis		
Year of Diagnosis (Month required if diagnosed within the past 12 months)	Patient Weight (kg)	Is Patient in Hospital? (coverage not provided for inpatient doses) ◯ Yes ◯ No
Details of the presentation and how diagnosis was made (include copies of applicable biopsy results, clinical criteria (i.e., SLICC/ACR))		
Course of disease (with response to treatments provided in Section 5)		
Provide a narrative detailing current severity		

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

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

Patient Name	PHN

SECTION 4 – DIAGNOSIS / CLINICAL INFORMATION (continued)

Provide current values of clinical measures relevant to the diagnosis used to assess efficacy of rituximab therapy in case renewal is required AND copies of reports/documents relevant to the diagnosis
Treatment Goals as per clinical measures provided above
List relevant co-morbiditites

SECTION 5 - TREATMENT HISTORY

Please provide details of all pharmacological and non-pharmacological treatments trialed including prednisone, IVIG, surgical procedures, and plasmapheresis. If a treatment would usually considered for a condition, but cannot be used due to patient specific contraindications, please provide details.

If a medication has been trialed at multiple doses (e.g. initial steroid treatment, followed by tapering) give details of the response to the treatment at the doses used. If more treatments have been used or considered than can be included below, please provide additional details in Section 8.

NAME	DOSING REGIMEN	STARTING DATE	END DATE	RESPONSE TO THERAPY OR CONTRAINDICATION

SECTION 6 - CURRENT MEDICATIONS

Current medications being used to treat moderate to severe autoimmune condition

MEDICATION	DOSE	FREQUENCY

Please complete additional information on page 3 >>

RITUXIMAB FOR AUTOIMMUNE CONDITIONS INITIAL/RENEWAL REQUEST

Patient Name	PHN

SECTION 7 – RENEWAL

Attach any clinical notes, consultations, laboratory and test results (e.g., radiology, complete blood count, serology, genetic testing results, etc.) that supports the request.

Anticipated Retreatment Date (approx, if exact not knowns)	Date of Most Recent Rituximab Dose	Year Rituximab Started

Details of improvement seen in symptoms and clinical measures relevant to the diagnosis at time of best response to **PRIOR** rituximab course

Details of the **CURRENT** severity of the patient's presentation requiring retreatment with rituximab

Current values of clinical measures provided on prior application(s) AND copies of relevant reports/documents

Details of treatment plan

SECTION 8 – ADDITIONAL COMMENTS

SECTION 9 – PRESCRIBING SPECIALIST'S SIGNATURE

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* 22(1) and *Freedom of Information and Protection of Privacy Act* 26 (a),(c),(e). The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection 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.

Prescribing Specialist'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.

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