BCRenal
an agency of the Provincial Health Services Authority

Application for Coverage of Immunosuppression Medications for ADULT GN Patients

Attach patient label or fill in below:

Patient Name: _____

Patient PHN: _____

Text

INSTRUCTIONS:

1. Ensure the patient is registered in PROMIS under the Provincial Renal Agency program.
   a. Choose the most appropriate GN diagnosis under the available list of primary renal diagnoses.
   b. Ensure the patient address and contact information are accurate as these are needed for medication distribution.
2. Complete the information below, fax this form **along with your prescription** to Macdonald's Pharmacy at **1-866-685-0305.** The medications will be delivered to the patient's home address.
3. Please note that coverage is medication specific and for 12 months, after which this form must be completed again to maintain coverage.
4. Coverage is contingent upon the approved medication being entered into PROMIS, with accurate dose changes and start/stop dates.

THE FOLLOWING ARE REQUIRED FOR MEDICATION APPROVAL:

GN Diagnosis with PROMIS codes (pick one):

- ☐ ANCA vasculitis / pauci-immune glomerulonephritis (69, 74 or 98)
- ☐ Anti-GBM antibody disease / Goodpasture's disease (86)
- ☐ FSGS (09 or 11)
- ☐ IgA nephropathy (12)
- ☐ Minimal change disease (06)
- ☐ Membranous nephropathy (14)
- ☐ Lupus nephritis (84), provide class _____
- ☐ Other: _____
- ☐ Additional details about diagnosis, if needed: _____

Weight: _____ **Height:** _____

Oral medications for coverage (pick all that apply):

- ☐ Azathioprine
- ☐ Cyclophosphamide
- ☐ Cyclosporine
- ☐ Mycophenolate Mofetil
- ☐ Myfortic®
- ☐ Prednisone
- ☐ Tacrolimus

If you are applying for MYFORTIC®, indicate the following:

- ☐ Patient has tried Mycophenolate Mofetil and been intolerant due to GI side-effects

If you are applying for TACROLIMUS, choose one of the following:

- ☐ Patient has tried Cyclosporine and been intolerant
- ☐ Patient has a contraindication to Cyclosporine

Reason(s) for above medication(s) (pick all that apply):

- ☐ Evidence based first-line immunosuppression regimen
- ☐ Disease is resistant to other immunosuppression medications
- ☐ Disease relapsed after other immunosuppression medications
- ☐ Patient is intolerant to other immunosuppression medications
- ☐ Patient has a contraindication to other immunosuppression medications

Date: _____ **Name:** _____

Contact Phone: _____ **Signature:** _____