BCRenal
Provincial Health Services Authority

Application for Coverage of ORAL Immunosuppression Drugs for GN Patients

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

Date of Birth (MM/DD/YYYY): _____

PHN: _____

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 this form only needs to be completed at initiation of each new oral immunosuppressant. However, If the patient has stopped therapy for 6 months or longer, then completing a new form is required.**
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):

GN Diagnosis with PROMIS codes (pick one):

- ☐ Azathioprine
- ☐ Cyclophosphamide
- ☐ Cyclosporine
- ☐ Mycophenolate Mofetil
- ☐ Mycophenolate Sodium → **If you are applying for Mycophenolate Sodium, indicate the following:**
  - ☐ Patient has tried Mycophenolate Mofetil and been intolerant due to GI side-effects
- ☐ Tacrolimus
- ☐ Prednisone
- ☐ Prednisolone

Liquid versions of these medications are available. Prescriptions for some liquid medications may be re-directed from Macdonald's to BC Children's Hospital Ambulatory Care Pharmacy as required.

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

Name: _____ Signature: _____

Phone: _____ Date: _____