BCRenal
Provincial Health Services Authority

Application for Coverage of riTUXimab for Glomerulonephritis

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

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

PHN: _____

▶ **PLEASE SIGN, DATE AND FAX THIS FORM TO: BC Renal (604) 875-7366**

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 to the BC Renal at (604) 875-7366.**
3. This application will be reviewed by the BC Renal Pharmacy Services and Formulary Committee; you will be contacted once approval is decided. **Please note, BC Renal covers the Riximyo™ biosimilar. Other biosimilars/ Rituxan® can be covered in specific circumstances, with appropriate justification provided.**
4. If approved, fax approval letter to the hospital pharmacy where riTUXimab will be infused, to inform them of BCR coverage.
5. Please note that coverage for riTUXimab is limited to one course; for subsequent treatment courses this form must be completed again.
6. Coverage is contingent upon the approved medication being entered into PROMIS, with accurate doses (including changes), frequency 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: _____
Provide body surface area if used for dosing: _____**m^2**

☐ 1000 mg
☐ 375 mg/m^2 = _____mg (round to nearest 50 mg)
☐ Other: _____mg (round to nearest 50 mg)

Frequency of infusions (pick one):
☐ Weekly
☐ Every 2 weeks
Other:_____

Total number of infusions: _____

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If you are applying for riTUXimab for ANCA vasculitis or pauci-immune glomerulonephritis:

☐ Provide details that confirm the patient has renal involvement.

_____

_____

* Note that patients without renal involvement are not eligible for BCR coverage and instead you should apply to BC PharmaCare through the Special Authority Process.

For **induction therapy**: indicate why cyclosphophamide can't be used AND provide details below.

- ☐ Disease is resistant to cyclophosphamide
- ☐ Cumulative previous exposure to cyclophosphamide exceeds the tolerable limit
  (exceeding 10 g increases the risk of infertility and exceeding 20 g increases the risk of malignancy)
- ☐ Patient has a contraindication to cyclophosphamide

Provide details that justify the above choice:

_____

_____

_____

_____

For **maintenance therapy:** indicate which of the following apply AND provide details below.

- ☐ Patient has a contraindication to the use of azathioprine maintenance therapy after a disease flare that included renal involvement.
- ☐ Patient is intolerant to at least 1.5 to 2 mg/kg/day of azathioprine maintenance therapy after induction treatment for a disease flare that included renal involvement.
- ☐ Disease relapse with renal involvement has occurred while on at least 1.5 to 2 mg/kg/day of azathioprine maintenance therapy.

Provide details that justify the above choice:

_____

_____

_____

_____

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If you are applying for riTUXimab for Membranous Nephropathy:

Provide justification for why this patient needs to **initiate** riTUXimab:

☐ Conservative therapy has been optimized (blood pressure control and maximal ACEi/ARB) for at least 6 months and proteinuria remains 3.5 g/day or greater.

☐ Other: _____

_____

Provide justification for why this patient needs to **continue** riTUXimab:

☐ The patient received riTUXimab 6 months ago and had a reduction in proteinuria by at least 25% from baseline, but is not in complete remission.

☐ Other: _____

_____

Provide laboratory values influencing treatment decisions (may provide a PROMIS printout instead):

Date (MM/DD/YYYY)					
eGFR					
Proteinuria*					
Serum albumin					

*provide type of test and units

Provide justification for the dosing amount and number of doses of riTUXimab:

☐ Dosing is as per the MENTOR study*.

☐ Other: _____

_____

_____

*In the MENTOR study, riTUXimab 1000 mg IV was given on Days 1 and 15. Patients who achieved complete remission at 6 months were not retreated. Another two doses of riTUXimab 1000 mg IV were administered 14 days apart at months 6 for individuals who had achieved a reduction in proteinuria by at least 25% from baseline but were not in complete remission.

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If you are applying for riTUXimab for another indication (not ANCA vasculitis, pauci-immune glomerulonephritis, or membranous nephropathy):

To justify the use of riTUXimab, please indicate why the following medications can't be used by checking the appropriate boxes AND briefly providing details:

	Disease Relapsed	Disease Resistant	Patient Intolerant	Contra-indicated	Not Indicated	Provide Details
Prednisone						
Azathioprine						
Mycophenolate/ Myfortic®						
Cyclosporine/ Tacrolimus						
Cyclophosphamide						

Provide any addition details that may support this application:

_____

_____

_____

_____

Name: _____ Signature: _____

Phone: _____ Date: _____

Fax number for approval notification (mandatory): _____

If you do not receive a response to your application within 72 hours, or if you'd like to check on the status of your application, please email us at medications@bcrenal.ca or call (604) 875-7340.