

Application for Coverage of riTUXimab for Glomerulonephritis

Rev: Jan/24

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

PATIENT INFORMATION LABEL

Name:

Address:

Phone:

Date of Birth (MM/DD/YYYY):

PHN:

INSTRUCTIONS

- Ensure the patient is registered in PROMIS under the Provincial Renal Agency program.
 - Choose the most appropriate GN diagnosis under the available list of primary renal diagnoses.
 - Ensure the patient address and contact information are accurate as these are needed for medication distribution.
- Complete the information below, **fax this form to the BC Renal at (604) 875-7366.**
- 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.**
- If approved, fax approval letter to the hospital pharmacy where riTUXimab will be infused, to inform them of BCR coverage.
- Please note that coverage for riTUXimab is limited to one course; for subsequent treatment courses this form must be completed again.
- 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: _____ m²

- 1000 mg
- 375 mg/m² = _____ 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 cyclophosphamide 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:**

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Name:

Address:

Phone:

Date of Birth (MM/DD/YYYY):

PHN:

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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Address: _____

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

PHN: _____

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 call (604) 875-7340.