Exceptional Coverage Request Form

Non-Formulary Oral Nutritional Supplement (ONS)

July 2026 Version 1.0

Complete all sections. Incomplete or partially completed forms will not be reviewed. Submit by email to BC Renal (contracts@bcrenal.ca).

REQUESTING PROVIDER (BC RENAL DIETITIAN)

Name

Date of request

Renal program / clinic

Health authority

Phone

Email (for return of decision)

PATIENT INFORMATION & ELIGIBILITY

PROMIS ID

Personal Health Number (PHN)

Date of birth (YYYY-MM-DD)

☐ Patient is registered in PROMIS under the Provincial Renal Agency program.

Is the patient a BC resident and registered with MSP and Fair PharmaCare? ☐ Yes ☐ No

Has the patient demonstrated a need for oral nutritional supplement? (patient must meet at least one of these criteria)

☐ A food-first approach to maximize nutrition has been attempted and deemed insufficient (oral intake of 80% or under for meeting nutritional needs, or continuously losing weight despite food-first therapy).

☐ Unintentional weight loss of 5-10% in the past 1-6 months.

☐ Subjective Global Assessment (SGA) score indicates malnutrition risk (see tool for scoring: PCA-SGA Branded Handout).

☐ A pediatric patient is unable to achieve an appropriate height and/or weight percentile for age.

Does the patient have no other means of funding for ONS (i.e., assistance from the Ministry of Social Development and Poverty Reduction, First Nations Health Authority)?

ONS REQUESTED

Name and flavour of non-formulary ONS

Indication for non-formulary ONS

Note: lifestyle preferences will not be considered.

This form contains confidential and personal health information intended only for BC Renal. If you have received this in error, please delete it and notify BC Renal.

Patient-specific factors for consideration (individualized goals of therapy and expected benefit)

Dose prescribed and maximum dose that may be required

Duration of therapy

Duration for which exceptional coverage is required
Note: request will be granted for up to 6 months.

Approximate cost of ONS for the indicated duration. If ONS need is chronic, please provide the estimated annual cost.

ALTERNATIVES & CLINICAL JUSTIFICATION

Has the patient tried any other alternative ONS? If so, please indicate products tried and response achieved.

If other ONS were not tried, please list and justify why they may not be appropriate, including any patient-specific factors.

If renewal of exceptional coverage is anticipated, please indicate the clinical parameters or outcomes that will be followed to reassess the ongoing need for the ONS.

Other information

This form contains confidential and personal health information intended only for BC Renal. If you have received this in error, please delete it and notify BC Renal.

Requests would not be considered in the following scenarios:

- Use of specific products based on patient lifestyle preference or dietary choice.
- Preference for specific brand or formulation for the sole reason that the brand or formulation was what was previously used in a different province or country.

Requesting provider signature

Date

To submit: Sign, date, and email the completed form to BC Renal at contracts@bcrenal.ca. Send the form as an attachment.

If you do not receive a response within 72 hours, or to check on status, email contracts@bcrenal.ca.

FOR BC RENAL OFFICE USE ONLY

Submission ID

Date received

Adjudicator(s)

Decision date

☐ Approved ☐ Denied Approval expires on:

This form contains confidential and personal health information intended only for BC Renal. If you have received this in error, please delete it and notify BC Renal.