Application for Sirolimus HEART Transplant Recipients

Please complete and fax to BCT Pharmacist at (604) 877-2111

DATE:

TO:

FROM:

BCT #:_______________________
Name: Last: _________________________________ First: ______________________
Hospital: _________________________ Cardiologist: _________________________

Indications for Sirolimus Use:
1. ☐ In addition to a calcineurin inhibitor in patients who have recurrent or persistent transplant rejection within the first year post transplant
2. ☐ Patient has developed cardiac allograft vasculopathy (CAV)
3. ☐ Patient has developed calcineurin inhibitor neurotoxicity or nephrotoxicity
1. ☐ Patient has developed cancer. Type:____________________________
2. ☐ Patient is following an out-of-province protocol.

Physician’s Signature: __________________________ Date: ____________

Approval by BCT: ____________________________ Date: ____________

NOV 2014