BCT Fax Form:

Application for Sirolimus RENAL Transplant Recipients

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

DATE:

TO:

FROM:

BCT#: ______________ Name: Last: __________________________ First: __________________________

Hospital: _________________________ Nephrologist: _________________________________________

Indications for Sirolimus Use:

1. ☐ Patient was enrolled in a sirolimus clinical study.

2. ☐ Patient has developed calcineurin inhibitor toxicity:
   a) Biopsy-proven, severe nephrotoxicity, while on calcineurin inhibitors despite blood concentrations within therapeutic range. Increase in serum creatinine must be at least 50% above baseline.
   - ☐ Cyclosporine
   - ☐ Tacrolimus
   b) Neurotoxicity:
   - ☐ Cyclosporine (date _____________)
   - ☐ Tacrolimus (date______________)

3. ☐ Patient has developed severe refractory BK virus-induced nephropathy while on a calcineurin inhibitor

4. ☐ Pediatric patient with refractory rejection.

5. ☐ Patient has recurrent skin cancer. ☐ Patient has renal cancer. ☐ Patient has another cancer:
   Specify other cancer type: ____________________________

PRIOR TO BEGINNING SIROLIMUS FOR SKIN CANCER INDICATION PATIENT MUST BE DISCUSSED WITH THE PRIMARY TRANSPLANT CENTRE

For other cancers: Sirolimus MUST be approved by a transplant nephrologist at the primary transplant centre:
Approved by ___________________________ Date (____________) at VGH ☐ SPH ☐

Physician’s Signature: __________________________ Date: ____________

Approval by BCT: ___________________________ Date: ______________

OCT 2014