BC TRANSPLANT
An agency of the Provincial Health Services Authority

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 <u>MUST</u> 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