BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

ANGIOTENSIN RECEPTOR BLOCKERS (ARBs) – RDP PROGRAM

HLTH 5492 Rev. 2025/07/03

◯ **E ARBs (Complete Sections 1-3)** ◯ **NON-REFERENCE ARBs (Complete Sections 1, 2, 4A and if applicable 4B)**

***Please note:** Coverage provided for PharmaCare eligible formulations. Most strengths and combination products are eligible for coverage; however some formulations (such as candesartan 4 mg) are not PharmaCare benefits.*

For up-to-date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority

Fax requests to 1-800-609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4

This facsimile is Doctor privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested medication is, or is not, suitable for any specific patient or condition.

If you have received this fax in error, please write MISDIRECTED across the front of the form and fax toll-free to 1-800-609-4884, then destroy the pages received in error.

Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.

SECTION 1 – PRESCRIBER INFORMATION

Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Prescriber's Fax Number

SECTION 2 – PATIENT INFORMATION

Patient (Family) Name	
Patient (Given) Name(s)	
Date of Birth (YYYY / MM / DD)	Date of Application (YYYY / MM / DD)
CRITICAL FOR PROCESSING →	Personal Health Number (PHN)

SECTION 3 – REFERENCE ARBs (FULL COVERAGE)

☐ Patient has experienced intractable cough or angioedema on an Angiotensin Converting Enzyme Inhibitor (ACE-I). Full coverage will be provided for all First Line ARBs.

Medication Requested **(select one)**

◯ **CANDESARTAN** ◯ **LOSARTAN** ◯ **TELMISARTAN** ◯ **VALSARTAN**

SECTION 4 – NON-REFERENCE ARBs (PARTIAL OR FULL COVERAGE)

4A. ☐ Patient has experienced intractable cough or angioedema on an Angiotensin Converting Enzyme Inhibitor (ACE-I). If ONLY this criteria met, PARTIAL coverage will be provided for non-reference ARBs (up to the daily drug cost for reference products). For consideration of full coverage also complete 4B below.

Medication Requested **(select one)**

◯ **OLMESARTAN** ◯ **IRBESARTAN**

4B. For consideration of FULL coverage of non-reference ARBs ALL reference ARBs must have been unsuccesfully tried as below:

REFERENCE ARB	CANDESARTAN	LOSARTAN	TELMISARTAN	VALSARTAN
Discontinued due to:	◯ Failure ◯ Intolerance	◯ Failure ◯ Intolerance	◯ Failure ◯ Intolerance	◯ Failure ◯ Intolerance
Approximate Dates of Trials:				

SECTION 5 – ADDITIONAL COMMENTS FOR CONSIDERATION OF COVERAGE

SECTION 6 – PRESCRIBER SIGNATURE

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* 22(1) and *Freedom of Information and Protection of Privacy Act* 26 (a),(c),(e). The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I have discussed with the patient that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.

Prescriber's Signature (Mandatory)

PharmaCare may request additional documentation to support this Special Authority request.
Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.

PHARMACARE USE ONLY

9901-0057 NB4 + 0024-0057 _____

STATUS	EFFECTIVE DATE (YYYY / MM / DD)	DURATION OF APPROVAL

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