Request for Ondansetron for Treatment of Methotrexate Induced Nausea and Vomiting Exceptional Access Program (EAP)

Ontario Rheumatology Association

To avoid delays, please ensure that all appropriate information for each section is provided.

Section 1 – Prescriber Information

First Name	Initial	Last Name

Street #	Street Name

City	Postal Code

Fax	Telephone (Back Line)

Type of Presriber: ◯ Physician ◯ Nurse Practitioner

Section 2 – Patient Information

First Name	Initial	Last Name

Ontario Health Insurance Number

Gender: ◯ Male ◯ Female

Current Weight (kg)

Date of Birth (DD/MM/YYYY)

Specialty of the Prescriber: ◯ Rheumatologist ◯ Other:

Request Type: ☐ New Request (complete all sections) ☐ Renewal Request (complete sections 3, 5B)

Is the patient currently taking the drug requested below? ◯ Yes - Start Date (DD/MM/YYYY): ◯ No

EAP #

Section 3 – Drug, Dose and Regimen Requested *(attach additional sheets if more space is required)*

☐ **ondansetron**

Refer to ondansetron prescribing information for appropriate dosing within the treated population.
In general, 2 to 8 mg per dose administered one hour prior to methotrexate with 1 to 2 additional doses as needed post-methotrexate dosing.

☐ ondansetron tablet ☐ ondansetron ODT ☐ ondansetron ODF (film) ☐ ondansetron 4mg/5ml oral liquid

Dosage	Dosing Frequency

Section 4 – Clinical Information

1. What is the chronic diagnosis for which methotrexate is being used? Specify:

Dosage	Dosing Frequency	Route of Administration: ◯ SC ◯ IV ◯ PO

2. Has the patient experienced the following after taking methotrexate?

Nausea: ◯ Yes ◯ No Approximate Date (MM/YYYY):

Vomiting: ◯ Yes ◯ No Approximate Date (MM/YYYY):

For patients who are older than 18 years requesting ondansetron, please provide clinical rationale including a description of the response to methotrexate.

Section 5A – Current and/or Previous Medications

Provide details of methotrexate dosing and list other concomitant medications.

Name of Drug	Dosing Regimen	Mode of Administration (e.g. po/sc)	Expected Duration

Section 5B – Renewal Information

Provide evidence of treatment effect for renewal (initial approval 2 years):

Prescriber Signature (Mandatory)	Registration Number	Date (DD/MM/YYYY)

Please fax the completed form and/or any additional relevant information to **416-327-7526** or toll free **1-866-811-9908**; or send to the Drug Programs Delivery Branch, 3rd Floor, 5700 Yonge Street, North York, Ontario, M2M 4K5. **For any patient under 25 please fax to OHIP + at 1-844-227-6590**. For copies of EAP forms, please visit: **http://ontariorheum.ca/drug-forms-and-codes/eap-forms**

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