



INITIAL Complete sections 1 - 3, 5

SWITCH Complete sections 1 - 4, 5A - 5C

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

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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.

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 - RHEUMATOLOGIST INFORMATION

Form for Section 1: Prescriber's Name and Mailing Address, Mail Confirmation, College ID, MSP Number, Phone Number, Prescriber's Fax Number, and Critical for a Timely Response indicator.

SECTION 2 - PATIENT INFORMATION

Form for Section 2: Patient (Family) Name, Patient (Given) Name(s), Date of Birth, Date of Application, Personal Health Number (PHN), and Critical for Processing indicator.

SECTION 3 - CURRENT CLINICAL INFORMATION

Form for Section 3: Medication Requested (Adalimumab, Certolizumab, Etanercept, Golimumab, Infliximab), Year of Diagnosis, Weight, ESR/CRP, Morning Stiffness, and Physician Global Assessment of Inflammation.

CURRENT MEDICATIONS (DMARDs, anti-inflammatories, corticosteroids, analgesics, opioids)

Table with 3 columns: DRUG, DOSE, FREQUENCY. Includes empty rows for data entry.

SECTION 4 - PRIOR TARGETED DMARDs AND REASON FOR DISCONTINUATION OR CONTRAINDICATIONS TO OTHER BIOLOGICS

Table with 4 columns: NAME, DOSE & FREQUENCY; DURATION, PLEASE SPECIFY DATES; FAILURE (Type I, Type II); SIDE EFFECT(S) OR CONTRAINDICATION(S) - PLEASE SPECIFY.

* Never achieving a 20% improvement
** At least 20% improvement in first 12 weeks of a TNF inhibitor but then loss of benefit

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

Form for Pharmacare Use Only: STATUS, EFFECTIVE DATE, DURATION OF THERAPY / TERMINATION DATE.

ADALIMUMAB / CERTOLIZUMAB / ETANERCEPT / GOLIMUMAB / INFLIXIMAB FOR PSORIATIC ARTHRITIS

PATIENT NAME	PHN	DATE (YYYY / MM / DD)
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SECTION 5 - CRITERIA FOR COVERAGE OF ONE YEAR – Patient must meet criteria in A, B, C and D below

A Current Status Of Cutaneous Psoriasis: none mild moderate severe

- B** Diagnosis of moderate to severe psoriatic arthritis, where patient currently exhibits at least **two** of the following (please indicate all that apply):
- Five or more active joints (**if yes, complete homunculus below**).
 - If oligoarticular (less than five joints), at least one active joint proximal to, or including, wrist or ankle (**if yes, complete homunculus below**).
 - More than one joint with erosion on imaging study.
 - Dactylitis of two or more digits (**indicate by arrow and “D” on homunculus below**).
 - Tenosynovitis refractory to oral NSAIDs AND steroid injections (**indicate by arrow and “TS” on homunculus below**).
 - Enthesitis refractory to oral NSAIDs AND steroid injections (not required for Achilles tendon) (**indicate by arrow and “E” on homunculus below**).
 - Inflammatory spinal symptoms refractory to two NSAIDs (minimum 4 week trial each) and submit a BASDAI with a score greater than 4.
 - Daily use of corticosteroids to control active arthritis.
 - Use of narcotics >12 hours per day for pain resulting from inflammation.

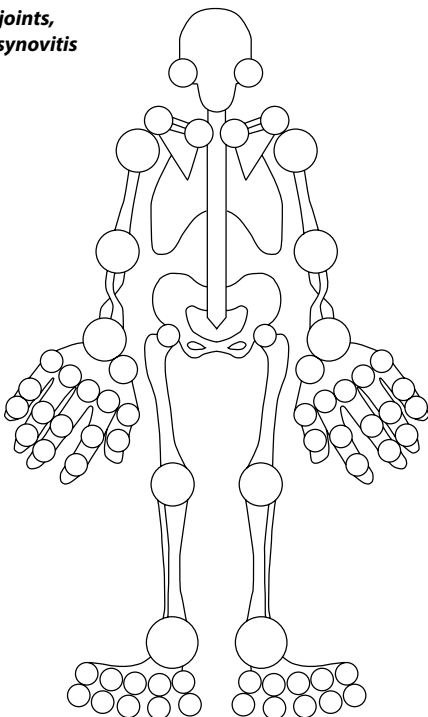
Specify drug and daily dose _____

C Functional assessment completed by patient and attached.
 Health Assessment Questionnaire (HAQ) **AND/OR** BASDAI (in spinal disease)

D Patient has failed two or more DMARDs:

	DOSE	FREQUENCY	DURATION	RESPONSE/ADVERSE EVENT
<input type="checkbox"/> Sulfasalazine (if allergic, must have failed two of the medications listed below).				
<input type="checkbox"/> Methotrexate: up to 25 mg (15 mg if over 65 years) parenteral weekly				
<input type="checkbox"/> IM gold				
<input type="checkbox"/> Chloroquine and/or hydroxychloroquine				
<input type="checkbox"/> Leflunomide				
<input type="checkbox"/> Cyclosporine				
<input type="checkbox"/> Other (specify)				

HOMUNCULUS
 Indicate active joints, dactylitis, tenosynovitis and enthesitis



Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).

Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* and *Freedom of Information and Protection of Privacy Act*. It will not be disclosed to any persons without the patient's consent. The information you provide will be relevant to and used solely to (a) provide PharmaCare benefits for the medication requested, (b) to implement, monitor and evaluate this and other Ministry programs, and (c) to manage and plan for the health system generally. If you have any questions about the collection or use 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.

 Rheumatologist'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.