



INITIAL

Complete sections 1-3, 5, plus 6-7 if applicable

SWITCH

Complete sections 1 - 4, 5A-5B, plus 6 if applicable

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-Patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited. If you have received this fax in error, please write "MIS-DIRECTED" across the front of the form and fax toll-free to 1 800 609-4884, then destroy the pages received in error.

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 - SPECIALIST INFORMATION

Form for Section 1: Rheumatologist's Name and Mailing Address, Mail Confirmation, College ID, MSP Number, Phone Number, Rheumatologist's Fax Number. Includes 'CRITICAL FOR A TIMELY RESPONSE' label.

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). Includes 'CRITICAL FOR PROCESSING' label.

SECTION 3 - CURRENT CLINICAL INFORMATION

Form for Section 3: Medication Requested (ADALIMUMAB, CERTOLIZUMAB, ETANERCEPT, GOLIMUMAB, INFLIXIMAB), Year of Diagnosis, Weight, ESR/CRP, Morning Stiffness, Physician Global Assessment.

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

Table with 3 columns: MEDICATION, DOSE, FREQUENCY

SECTION 4 - PRIOR TARGETED DMARDs AND REASON FOR DISCONTINUATION

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

* Never achieving a 20% improvement

** At least 20% improvement in first 12 weeks of a TNF inhibitor but loss of benefit

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

Table with 3 columns: STATUS, EFFECTIVE DATE (YYYY / MM / DD), DURATION OF APPROVAL

| | |
|--------------|-----|
| PATIENT NAME | PHN |
|--------------|-----|

SECTION 5 - CRITERIA FOR COVERAGE OF ONE YEAR

Patient must meet criteria in A, B, and C below.

A Diagnosis of moderate to severe ankylosing spondylitis. Complete **all** that apply:

Extra-articular manifestations. Specify: _____

AXIAL DISEASE

Positive imaging finding of ankylosing spondylitis. Changes seen: _____ Imaging method used: _____
If no positive imaging, please provide HLA B27 status and spondyloarthropathy features in Section 7 below.

Presence of spinal pain. Specify degree of spinal pain: Mild Moderate Severe

PERIPHERAL DISEASE

Active joints (complete homunculus below) Active Tenosynovitis and/or Enthesitis (indicate by arrow and "TS" or "E" on homunculus as applicable)

B Active ankylosing spondylitis with a BASDAI score ≥ 4 . Copy of BASDAI attached. Copy of HAQ attached if predominantly peripheral disease.

C For predominantly axial disease, treatment failure or intolerance to three NSAIDs for a minimum of two weeks each at accepted maximum dosage:

Specify the three NSAIDs tried: DOSE FREQUENCY DURATION RESPONSE / ADVERSE EVENT

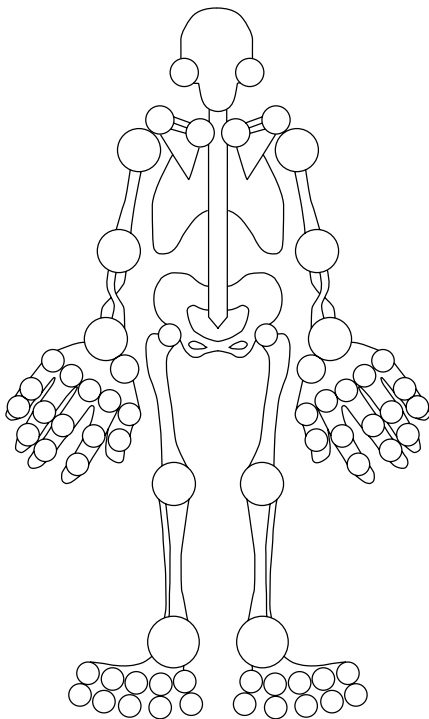
| Specify the three NSAIDs tried: | DOSE | FREQUENCY | DURATION | RESPONSE / ADVERSE EVENT |
|---------------------------------|------|-----------|----------|--------------------------|
| | | | | |
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| | | | | |

OR, for predominantly peripheral disease, patient is refractory to minimum 3 month trials of each of the following:

| | DOSE | FREQUENCY | DURATION | RESPONSE / ADVERSE EVENT |
|--|------|-----------|----------|--------------------------|
| 1. <input type="checkbox"/> Methotrexate up to 25 mg (15 mg over 65 years) parenteral weekly | | | | |
| 2. <input type="checkbox"/> Sulfasalazine up to 3g daily | | | | |

SECTION 6 – HOMUNCULUS

Indicate active joints, tenosynovitis and enthesitis.



SECTION 7 – SPONDYLOARTHROPATHY (SpA) FEATURES

If no positive imaging, please confirm patient is HLA B27+ and provide at least two additional SpA features below.

Confirmation Patient is HLA B27+

Additional SpA Features:

- | | | |
|---|--|--|
| <input type="checkbox"/> inflammatory back pain | <input type="checkbox"/> dactylitis | <input type="checkbox"/> good response to NSAIDs |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> psoriasis | <input type="checkbox"/> family history for SpA |
| <input type="checkbox"/> enthesitis | <input type="checkbox"/> Crohn's / colitis | <input type="checkbox"/> elevated CRP |
| <input type="checkbox"/> uveitis | | |

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.