BRITISH COLUMBIA | Ministry of Health

*SPECIAL AUTHORITY REQUEST*

**ADALIMUMAB / INFLIXIMAB / VEDOLIZUMAB FOR MODERATE TO SEVERE ACTIVE CROHN'S / FISTULIZING CROHN'S DISEASE**

HLTH 5495 Rev. 2022/07/25

# RENEWAL COVERAGE

**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 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 – PRESCRIBING GASTROENTEROLOGIST'S INFO.

| 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 – MEDICATION REQUESTED

◯ **ADALIMUMAB** **1 year:** 40 mg every 2 weeks

◯ **ABRILADA®** ◯ **AMGEVITA®** ◯ **HADLIMA® *** ◯ **HULIO®**
◯ **HYRIMOZ®** ◯ **IDACIO®** ◯ **SIMLANDI™** ◯ **YUFLYMA®**

◯ _____

** Adults only*

◯ **INFLIXIMAB** **1 year:** 5 mg/kg every 8 weeks

◯ **AVSOLA™** ◯ **INFLECTRA®** ◯ **RENFLEXIS®**

◯ _____

◯ **VEDOLIZUMAB** ◯ **1 year:** 300 mg every 8 weeks
◯ **1 year:** 108 mg SC every 2 weeks

◯ _____

## SECTION 4 – POST INDUCTION /CURRENT CLINICAL INFORMATION

| Diagnosis | Impact of Current Condition on Work/Social Life | Current Weight In Kg | Current Steroid Dose |
|---|---|---|---|
| ◯ Moderate to Severe Active Crohn's ◯ Active Fistulizing Crohn's | ◯ None ◯ Mild ◯ Moderate ◯ Severe | | |

**FOR MODERATE TO SEVERE CROHN'S**

| Duration Of Effect (days) | Current **Harvey Bradshaw Index** *(must be a decrease of ≥ 4 points or ≤ 5 points total)* |
|---|---|

**FOR ACTIVELY FISTULIZING CROHN'S**

| Site of Fistula(e) | Number of Fistulae |
|---|---|
| ◯ Perianal ◯ Enterocutaneous ◯ Recto-Vaginal ◯ Other (specify) | |

| Fistula Drainage and Bleeding | Pain at Fistula Sites |
|---|---|
| ◯ None ◯ Mild ◯ Moderate ◯ Severe | ◯ None ◯ Mild ◯ Moderate ◯ Severe |

For consideration of ongoing off-criteria coverage, additional details demonstrating medication efficacy are required. The current submitted assessment must be equivalent to the baseline assessment previously submitted. Initial requests for off-criteria coverage (i.e. dose escalation), require details demonstrating ongoing moderate to severe active disease/low drug level. Please track the chosen assessment in section 6 for consideration of off-criteria coverage.

**Continued on page 2 >>**

## PHARMACARE USE ONLY

| Status | Effective Date (YYYY / MM / DD) | Duration of Approval |
|---|---|---|
| | | |

| PATIENT NAME | PHN | DATE (YYYY / MM / DD) |
|---|---|---|
| | | |

## SECTION 5 – CONCURRENT THERAPY

***INCLUDE ALL antidiarrheals, narcotics, immunosuppressants, antibiotics***

| | DRUG, DOSE/ROUTE, FREQUENCY |
|---|---|
| 1 | |
| 2 | |
| 3 | |

## SECTION 6 – CLINICAL MONITORING

***(only required for off-criteria requests)***

**Track the need for therapy (changes) and benefit from therapy (changes) for off-criteria consideration.**

| MONITORING PARAMETER | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| Endoscopy Score (SES-CD>7, isolated TI disease >3) | Date | | | | |
| | Finding | | | | |
| Fecal Calprotectin (>250) | Date | | | | |
| | Finding | | | | |
| Drug Level | Date | | | | |
| | Finding | | | | |
| Other (specify) | Date | | | | |
| | Finding | | | | |

## SECTION 7 – ADDITIONAL INFORMATION, IF APPLICABLE

***Include any changes to therapy, surgical interventions, explain gaps in therapy.***

## SECTION 8 – 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.***

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