BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

ADALIMUMAB / INFLIXIMAB / OZANIMOD/ TOFACTINIB / VEDOLIZUMAB FOR ULCERATIVE COLITIS

HLTH 5388 Rev. 2024/01/08

INITIAL/SWITCH 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

INDUCTION

◯ **ADALIMUMAB** **12 week supply:** 160 mg week 0, 80 mg week 2, then 40 mg weeks 4, 6, 8, and 10

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

◯ **INFLIXIMAB** **3 doses:** 5 mg/kg at 0, 2, and 6 weeks

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

◯ **OZANIMOD** **14 week supply:** 0.23 mg once daily on days 1-4, then 0.46 mg one daily on days 5-7, then 0.92 mg once daily thereafter

◯ **TOFACTINIB** **8 week supply:** 10 mg twice daily for 8 weeks

◯ **VEDOLIZUMAB**
◯ **3 doses:** 300 mg at 0, 2, and 6 weeks
◯ **12 weeks:** 300 mg IV at 0, 2, and 6 weeks, plus 108 mg SC at weeks 8, 10, and 12

SECTION 4 – PRE-TREATMENT CLINICAL INFORMATION

Diagnosis	Year of UC Diagnosis	Impact of Current Condition on Work/Social Life	Current Weight In Kg	Current Steroid Dose
◯ Ulcerative Colitis		◯ None ◯ Mild ◯ Moderate ◯ Severe		

Normal Bowel Movements: ☐ (Patient's normal average daily number of bowel movements when in remission or before diagnosis and symptoms of ulcerative colitis began)

Endoscopic Findings (Optional) ◯ Normal or Inactive Colitis ◯ Mild Colitis ◯ Moderate Colitis ◯ Severe Colitis

Coverage: requires a score of ≥ 4, with rectal a bleeding subscore of ≥ 2

Stool Frequency (based on the last 3 days)		**Rectal Bleeding (based on the last 3 days)**		**Physician's Global Assessment**	
◯ normal number of stools	= 0	◯ no blood seen	= 0	◯ normal	= 0
◯ 1 - 2 stools more than normal	= 1	◯ streaks of blood with stool less than half the time	= 1	◯ mild colitis	= 1
◯ 3 - 4 stools more than normal	= 2	◯ obvious blood with stool most of the time	= 2	◯ moderate colitis	= 2
◯ 5 or more stools more than normal	= 3	◯ blood alone passed	= 3	◯ severe colitis	= 3
SCORE ☐		SCORE ☐		SCORE ☐	

Total Score (sum of stool frequency, rectal bleeding, and physician's global assessment) ☐ TOTAL SCORE

For consideration of off-criteria requests, additional information demonstrating moderate to severe active disease are required. If approved, an equivalent assessment is required within 9 months of starting treatment to demonstrate medication efficacy. Patient information enclosed:

☐ Colonoscopy ☐ Fecal Calprotectin Level ☐ Other (specify) _____

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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 – PRIOR THERAPIES (INITIAL COVERAGE)

Details of trial with 5-ASA products (for a minimum of 4 weeks)

Specify Drug Name and Dose	Details of Outcome (Failure, Contraindication, Intolerance, Other)
	◯ Lack of Effect ◯ Contraindication ◯ Intolerance ◯ Other Specify:

Details of glucocorticoid trial (required)

◯ **Patient has had a course of steroids equivalent to oral prednisone 40 mg or more daily for a minimum of 14 days.**

- ◯ Patient is steroid **resistant**, displaying a lack of **symptomatic response** to therapy.
- ◯ Patient is steroid **dependent**: unable to withdraw oral corticosteroid within 3 months of initiation without a recurrence of symptoms; a symptomatic relapse within 3 months of stopping; or the need for two or more courses of corticosteroids within one year.

OR

◯ **Patient is unable to complete a course of steroids equivalent to oral prednisone 40 mg or more daily for a minimum of 14 days.**

- ◯ Corticosteroid use is contraindicated (specify): _____
- ◯ Intolerances/side effect(s) (specify): _____

OTHER MEDICATION	STARTING DATE	DURATION OF USE	OUTCOME (specify intolerances, primary/secondary failures)

SECTION 7 – ADDITIONAL INFORMATION, IF APPLICABLE

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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