BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

BIOSIMILAR RITUXIMAB / TOCILIZUMAB FOR NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

HLTH 5851 Rev. 2025/05/07

◯ **INITIAL**
Complete sections 1 – 4

◯ **RENEWAL**
Complete sections 1 – 3, & 5

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 device 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 – NEUROLOGIST'S INFORMATION

Neurologist's Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Neurologist'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

◯ **BIOSIMILAR RITUXIMAB** **9901-0348**
Riximyo®, Ruxience®, Truxima®
Initial Coverage:
1000 mg IV at 0 & 2 weeks, followed by
1000 mg IV every 6 months
Renewal coverage: 1000 mg IV every 6 months

◯ **BIOSIMILAR TOCILIZUMAB** **9901-0484**
Tyenne®
Dosage: 8mg/kg IV every 4 weeks (maximum dose 800 mg)
162mg SC every 7 to 14 days

SECTION 4 – INITIAL COVERAGE CRITERIA

PharmaCare coverage is considered when rituximab/tocilizumab is prescribed by a neurologist with expertise in the diagnosis and management of NMOSD.

☐ For the treatment of NMOSD. Tocilizumab should not be initiated during a NMOSD relapse episode.
Provide most recent EDSS score and date taken.The EDSS score must be from within the 3 month period immediately preceding this request.

Most recent EDSS score _____ , date _____ .

Patient has experienced one of the following:

◯ Severe first attack (e.g., marked change in neurological functioning, requiring hospitalization or plasma exchange) or high disability with first attack (e.g., bilateral, or significant visual acuity loss worse than 6/60 or Expanded Disability Status Scale (EDSS) 5 at attack nadir).

OR

◯ Treatment failure resulting in at least one moderate to severe relapse of NMOSD within the previous 12 months despite a trial of optimally dosed first-line therapy, or a documented intolerance or contraindication to a first-line therapy.

	NAME OF PREVIOUSLY TRIED THERAPIES	DOSE	DURATION OF TRIAL (MONTHS)	DETAILS OF OUTCOME (FAILURE, CONTRAINDICATION, INTOLERANCE, OTHER)
1				◯ Failure ◯ Intolerance ◯ Contraindication Specify:
2				◯ Failure ◯ Intolerance ◯ Contraindication Specify:

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE	DURATION OF THERAPY / TERMINATION DATE

BIOSIMILAR RITUXIMAB / TOCILIZUMAB FOR NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

PATIENT NAME	PHN	DATE (YYYY / MM / DD)

SECTION 5 – RENEWAL COVERAGE CRITERIA: 12 MONTHS

PharmaCare coverage is considered when rituximab/tocilizumab is prescribed by a neurologist with expertise in the diagnosis and management of NMOSD.

☐ Patient has maintained an EDSS score of less than 8 points taken within the 3-month period immediately preceding the renewal request.

Most recent EDSS score _____ , date _____ .

SECTION 6 – ADDITIONAL NOTES

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.

_____

Neurologist'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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