BRITISH COLUMBIA | Ministry of Health

*SPECIAL AUTHORITY REQUEST*

# INHALERS FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

HLTH 5362 Rev. 2022/10/17

◯ **LIMITED COVERAGE LONG ACTING MUSCARINIC ANTAGONIST (LAMA) INHALERS**
**Complete sections 1, 2 and 3**

◯ **LONG ACTING BETA-AGONIST (LABA) INHALERS**
**Complete sections 1, 2 and 4**

◯ **LAMA / LABA COMBINATION INHALERS**
**Complete sections 1, 2 and 5 (page 2)**

◯ **INHALED CORTICOSTEROID (ICS) / LABA COMBINATION INHALERS**
**Complete sections 1, 2 and 6 (page 2)**

◯ **ICS / LAMA / LABA COMBINATION INHALERS**
**Complete sections 1, 2 and 7 (page 2)**

**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 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 – PRESCRIBER INFORMATION

| 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 – LIMITED COVERAGE LAMA INHALERS Select product below: 9901-0164

◯ **Aclidinium (TUDORZA GENUAIR)** ◯ **Tiotropium (SPIRIVA HANDIHALER)** ◯ **Glycopyrronium (SEEBRI BREEZHALER)**

☐ Failure of ALL of the Regular Benefit long-acting muscarinic receptor antagonist (LAMA) devices after a minimum one-month trial of EACH device:

☐ Tiotropium (SPIRIVA RESPIMAT) **AND** ☐ Umeclidinium (INCRUSE ELLIPTA)

## SECTION 4 – LABA INHALERS Select product below:

◯ **Salmeterol (SEREVENT) 9901-0341** ◯ **Indacaterol (ONBREZ BREEZHALER) 9901-0229** (Maximum dose of 75mcg daily)

☐ Diagnosis of COPD with a post-bronchodilator FEV1/FVC < 0.70. Please specify **FEV1/FVC ratio: 0.** _____

**AND**

☐ Contraindication or intolerance to a long-acting muscarinic receptor antagonist (LAMAs)

Please specify nature and severity of contraindication or intolerance: _____

*Please submit applications for LABA inhalers in asthma on the general special authority form.*

## PHARMACARE USE ONLY

| STATUS | EFFECTIVE DATE (YYYY / MM / DD) | DURATION OF APPROVAL |
|---|---|---|
| | | |

| PATIENT (FAMILY) NAME | PATIENT (GIVEN) NAME(S) | PERSONAL HEALTH NUMBER (PHN) |
|---|---|---|
| | | |

## SECTION 5 – LAMA / LABA COMBINATION INHALERS Select product below: 9901-0342

◯ **Aclidinium/Formoterol (DUAKLIR GENUAIR)**
◯ **Indacaterol/Glycopyrronium (ULTIBRO BREEZHALER)**
◯ **Tiotropium/Olodaterol (INSPIOLTO RESPIMAT)**
◯ **Umeclidinium/Vilanterol (ANORO ELLIPTA)**

☐ Diagnosis of moderate to very severe COPD with a post-bronchodilator FEV1/FVC < 0.70 AND a post-bronchodilator FEV1 < 80% predicted.

Please specify **FEV1/FVC ratio: 0.** _____ **AND FEV1:**_____ **%**

**AND**

☐ Inadequate response after **minimum of 6 month trial** of either LAMA or LABA. Please specify LAMA or LABA tried: _____

## SECTION 6 – INHALED CORTICOSTEROID (ICS) / LABA COMBINATION INHALERS 9901-0063

◯ **Fluticasone Propionate/Salmeterol (ADVAIR/GENERICS)**
◯ **Fluticasone Furoate/Vilanterol (BREO ELLIPTA 100/25 only)**

☐ Diagnosis of moderate to very severe COPD with a post-bronchodilator FEV1/FVC < 0.70 AND a post-bronchodilator FEV1 < 80% predicted.

Please specify **FEV1/FVC ratio: 0.** _____ **AND FEV1:**_____ **%**

**AND**

☐ Inadequate response after **minimum of 6 month trial** of either LAMA or LABA. Please specify LAMA or LABA tried: _____

**AND EITHER OF THE FOLLOWING**

◯ History of ≥ 2 moderate exacerbations in the previous 12 months, defined as requiring a prescribed antibiotic and/or using systemic glucocorticoids.
◯ History of ≥ 1 severe exacerbation in the previous 12 months defined as requiring a hospital admission or emergency department visit.

## SECTION 7 – ICS / LAMA / LABA COMBINATION INHALERS 9901-0340

◯ **Fluticasone Furoate/Umeclidinium/Vilanterol (TRELEGY ELLIPTA 100/62.5/25 only)**
◯ **Budesonide/Glycopyrronium/Formoterol (BREZTRI AEROSPHERE)**

☐ Diagnosis of moderate to very severe COPD with a post-bronchodilator FEV1/FVC < 0.70 AND a post-bronchodilator FEV1 < 80% predicted.

Please specify **FEV1/FVC ratio: 0.** _____ **AND FEV1:**_____ **%**

**AND EITHER OF THE FOLLOWING:**

◯ Inadequate response after **minimum of 6 month trial** of a LAMA/LABA combination inhaler. Please specify product: _____

◯ Inadequate response after **minimum of 6 month trial** of a ICS/LABA combination inhaler. Please specify product: _____

**AND EITHER OF THE FOLLOWING**

◯ History of ≥ 2 moderate exacerbations in the previous 12 months, defined as requiring a prescribed antibiotic and/or using systemic glucocorticoids.
◯ History of ≥ 1 severe exacerbation in the previous 12 months defined as requiring a hospital admission or emergency department visit.

## SECTION 8 – COMMENTS

## SECTION 9 – PRESCRIBER'S 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.***

**Report all adverse events to Canada Vigilance toll-free 1-866-234-2345 (health professionals only).**

Save Print Clear Form