

PHARMACARE SPECIAL AUTHORITY REQUEST  
TARGETED DMARDs FOR PSORIATIC ARTHRITIS  
RENEWAL / DOSING ADJUSTMENT

HLTH 5361 Rev. 2023/01/30

For up-to-date criteria and forms, please check: [www.gov.bc.ca/pharmacarespecialauthority](http://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.

**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.**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.

## SECTION 1 – RHEUMATOLOGIST INFORMATION

Prescriber's Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
<b>CRITICAL FOR A TIMELY RESPONSE</b> →	Rheumatologist'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)
<b>CRITICAL FOR PROCESSING</b> →	Personal Health Number (PHN)

## SECTION 3 – MEDICATION REQUESTED

Requested Dose and Interval _____ mg, every: _____	Patient's Body Weight (if significantly changed) _____ kg
<input type="radio"/> <b>ADALIMUMAB:</b> 40 mg every two weeks <input type="radio"/> Indefinite coverage <b>OR</b> <input type="radio"/> Renewal of three years <b>OR</b> <input type="radio"/> Renewal of one year  <input type="radio"/> ABRILADA® <input type="radio"/> AMGEVITA® <input type="radio"/> HADLIMA® <input type="radio"/> HULIO® <input type="radio"/> HYRIMOZ® <input type="radio"/> IDACIO® <input type="radio"/> SIMLANDI™ <input type="radio"/> YUFLYMA®	<input type="radio"/> <b>GOLIMUMAB:</b> 50 mg SC, once per month <input type="radio"/> Renewal of one year
<input type="radio"/> <b>CERTOLIZUMAB:</b> 200 mg every other week or 400 mg every 4 weeks <input type="radio"/> Indefinite coverage <b>OR</b> <input type="radio"/> Renewal of three years <b>OR</b> <input type="radio"/> Renewal of one year	<input type="radio"/> <b>INFLIXIMAB:</b> 3-5 mg/kg every 8 weeks <input type="radio"/> Indefinite coverage <b>OR</b> <input type="radio"/> Renewal of three years <b>OR</b> <input type="radio"/> Renewal of one year  <input type="radio"/> AVSOLA® <input type="radio"/> INFLECTRA® <input type="radio"/> RENFLEXIS®
<input type="radio"/> <b>ETANERCEPT:</b> total dose of 50 mg weekly <input type="radio"/> Indefinite coverage <b>OR</b> <input type="radio"/> Renewal of three years <b>OR</b> <input type="radio"/> Renewal of one year  <input type="radio"/> BRENZYS® 50 mg <input type="radio"/> ERELZI® 25, 50 mg	<input type="radio"/> <b>IXEKIZUMAB:</b> 80 mg every 4 wks for 1 year <input type="radio"/> Renewal of one year
	<input type="radio"/> <b>SECUKINUMAB:</b> 150 mg monthly or 300 mg monthly <input type="radio"/> Renewal of one year

If approved, please note that claims with indefinite SA approvals will be monitored and any overuse or significant underuse will be subject to review.

## SECTION 4 – CURRENT CLINICAL INFORMATION

ESR	or	CRP	MORNING STIFFNESS (MINUTES)	PHYSICIAN GLOBAL ASSESSMENT OF <b>INFLAMMATION</b> (SCALE OF 0 - 10), 0 = REMISSION, 10 = SEVERE ACTIVE DISEASE)	
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## PHARMACARE USE ONLY

Please complete additional information on page 2 &gt;&gt;

STATUS	EFFECTIVE DATE	DURATION OF THERAPY / TERMINATION DATE
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# TARGETED DMARDs FOR PSORIATIC ARTHRITIS

PATIENT NAME	PHN	DATE (YYYY / MM / DD)
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## SECTION 5 - CURRENT MEDICATIONS (DMARDs, anti-inflammatories, corticosteroids, opioids)

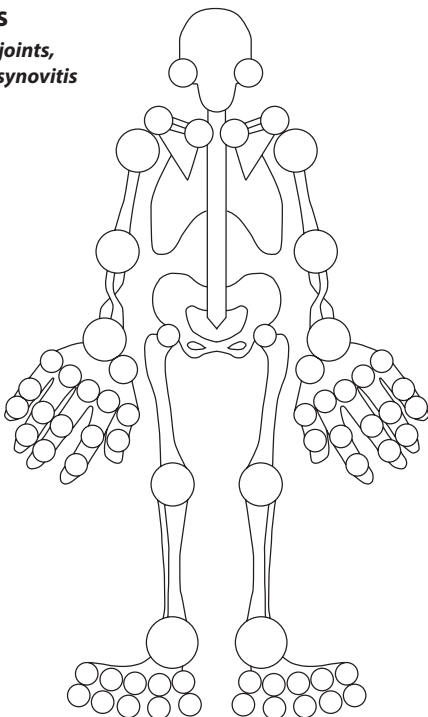
DRUG	DOSE	FREQUENCY

## SECTION 6 - CRITERIA FOR RENEWAL

<b>A</b> Status of cutaneous psoriasis: <input type="radio"/> Never Present <input type="radio"/> Resolved <input type="radio"/> Not Resolved → <b>If not resolved:</b> <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe		
<b>B</b> For the criteria <b>originally specified</b> in the request for initial coverage, please provide current status.	<b>IMPROVEMENT</b>	
	RESOLVED	NOT RESOLVED (ADDITIONAL COMMENTS IF APPLICABLE)
	Five or more swollen joints ( <b>please complete homunculus below</b> )	
	Oligoarthritis ( <b>please complete homunculus below</b> )	
	Dactylitis ( <b>indicate by arrow and "D" on homunculus below</b> )	
	Tenosynovitis ( <b>indicate by arrow and "TS" on homunculus below</b> )	
	Enthesitis ( <b>indicate by arrow and "E" on homunculus below</b> )	
	Inflammatory spinal symptoms (submit current BASDAI)	
	Daily use of corticosteroids to control active arthritis.	
Use of narcotics for pain resulting from inflammation	DRUG	CURRENT DOSE
<input type="checkbox"/> Functional assessment completed by patient and attached <input type="checkbox"/> Health Assessment Questionnaire (HAQ) <b>AND/OR</b> <input type="checkbox"/> BASDAI (in spinal disease)		
ADDITIONAL COMMENTS REGARDING PATIENT'S CURRENT MEDICAL STATUS		

### HOMUNCULUS

Indicate active joints, dactylitis, tenosynovitis and enthesitis



**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 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.

\_\_\_\_\_  
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.*