BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST
TARGETED DMARDs FOR RHEUMATOID ARTHRITIS
RENEWAL / DOSING ADJUSTMENT

HLTH 5354 Rev. 2023/04/06

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 – PRESCRIBING RHEUMATOLOGIST'S INFORMATION

Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	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)
CRITICAL FOR PROCESSING →	Personal Health Number (PHN)

SECTION 3 – MEDICATION REQUESTED *(all targeted DMARDs are more efficacious when combined with a DMARD, such as methotrexate)*

Requested Dose and Interval
_____ mg, every: _____

Patient's Body Weight (if significantly changed)
_____ kg

◯ **ABATACEPT:** Subcutaneous 125 mg weekly
Intravenous: weight <60 kg: 500 mg, 60-100 kg: 750 mg
>100 kg: 1000 mg every 4 weeks
◯ **Indefinite coverage**
OR ◯ **Renewal of three years**
OR ◯ **Renewal of one year**

◯ **ADALIMUMAB:** 40 mg every two weeks
◯ **Indefinite coverage**
OR ◯ **Renewal of three years**
OR ◯ **Renewal of one year**
◯ **ABRILADA®** ◯ **AMGEVITA®** ◯ **HADLIMA®** ◯ **HULIO®**
◯ **HYRIMOZ®** ◯ **IDACIO®** ◯ **SIMLANDI™** ◯ **YUFLYMA®**

◯ **CERTOLIZUMAB:** 200 mg every other week or 400 mg every 4 weeks
◯ **Indefinite coverage**
OR ◯ **Renewal of three years**
OR ◯ **Renewal of one year**

◯ **ETANERCEPT:** total dose of 50 mg weekly
◯ **Indefinite coverage**
OR ◯ **Renewal of three years**
OR ◯ **Renewal of one year**
◯ **BRENZYS®** 50 mg ◯ **ERELZI®** 25, 50 mg

◯ **GOLIMUMAB:** 50 mg SC. once per month in combination with a csDMARD
◯ **Renewal of one year**

◯ **INFLIXIMAB:** 3 mg/kg every 8 weeks in combination with a csDMARD
◯ **Indefinite coverage**
OR ◯ **Renewal of three years**
OR ◯ **Renewal of one year**
◯ **AVSOLA®** ◯ **INFLECTRA®** ◯ **RENFLEXIS®**

◯ **SARILUMAB:** 200 mg every 2 weeks or 150 mg every 2 weeks
◯ **Renewal of one year**

◯ **TOCILIZUMAB:** Intravenous: 4-8 mg/kg every 4 weeks (Max Dose 800 mg)
Subcutaneous: 162 mg every other week
Subcutaneous: 162 mg weekly
◯ **Indefinite coverage**
OR ◯ **Renewal of three years**
OR ◯ **Renewal of one year**

◯ **TOFACITINIB:** 5 mg twice daily or 11 mg XR once daily. Reimbursement for tofacitinib 11 mg XR will be up to the equivalent pricing for two 5 mg tablets.
◯ **Indefinite coverage**
OR ◯ **Renewal of three years**
OR ◯ **Renewal of one year**

PHARMACARE USE ONLY

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

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

SECTION 4 – CURRENT CLINICAL INFORMATION

68 JOINT COUNT: No. of Swollen Joints	No. of Tender Joints	ESR or CRP	Duration of Morning Stiffness	Dose of Prednisone

Physician Overall Assessment of Inflammation
(scale of 0 -10) 0 = remission, 10 = severe active disease

☐ Attached: Health Assessment Questionnaire (HAQ) completed by patient

CONCURRENT DMARD THERAPY:

OR

☐ MARK HERE IF NONE AND SPECIFY REASONS FOR MONTHERAPY IN SECTION 5.

DRUG	DOSE	ROUTE	FREQUENCY

SECTION 5 – NOTES (additional comments regarding patient's current medical status as applicable)

If patient's concurrent csDMARD has been discontinued, please give explanation below.

Report all adverse events to the post-market surveillance program, Canada Vigilance, toll-free 1-866-234-2345 (health professionals only).

SECTION 7 – RHEUMATOLOGIST'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.

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.

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