BRITISH COLUMBIA | Ministry of Health

# *SPECIAL AUTHORITY REQUEST*
# TARGETED DMARDs FOR RHEUMATOID ARTHRITIS
# INITIAL / SWITCH

HLTH 5345 Rev. 2024/06/12

◯ **INITIAL (complete sections 1-3, 5-7)** ◯ **SWITCH (complete sections 1-5, 7)**

**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**



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.***

## 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)*

**INITIAL ONE YEAR COVERAGE - for the treatment of moderately to severely active rheumatoid arthritis**

◯ **ABATACEPT**
- ◯ Subcutaneous: 125 mg weekly
- ◯ Intravenous: weight <60 kg: 500 mg, 60-100 kg: 750 mg, >100 kg: 1000 mg at 0, 2 and 4 weeks, then every 4 weeks.

◯ **ADALIMUMAB** 40 mg every 2 weeks

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

◯ **CERTOLIZUMAB** 400 mg at 0, 2 and 4 weeks, followed by 200 mg every other week or 400 mg every 4 weeks.

◯ **ETANERCEPT** 50 mg weekly

◯ **BRENZYS®** 50 mg ◯ **ERELZI®** 25, 50 mg ◯ **RYMTI®** 50 mg

◯ **GOLIMUMAB** 50 mg SC once per month; must be given in combination with a csDMARD:
- ◯ Methotrexate
- ◯ Other (specify):

◯ **INFLIXIMAB** 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks; must be given in combination with a csDMARD:
- ◯ Methotrexate
- ◯ Other (specify):

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

◯ **SARILUMAB** 200 mg every 2 weeks; also approved for 150 mg every 2 week dosing if needed

◯ **TOCILIZUMAB**
- ◯ Intravenous: 4 mg/kg (up to 800 mg) every 4 weeks
- ◯ Intravenous: 8 mg/kg (up to 800 mg) every 4 weeks with explanation:

_____

- ◯ Subcutaneous:
  - Patients less than 100 kg – starting dose of 162 mg every other week, followed by an increase to weekly based on clinical response.
  - Patients at or above 100 kg – 162 mg weekly.

◯ **TOFACITINIB** 5 mg twice daily, or 11 mg once daily of the XR formulation, with methotrexate (or without methotrexate in cases of methotrexate intolerance). Reimbursement for tofacitinib 11 mg XR will be up to the equivalent pricing for two 5 mg tablets.

## SECTION 4 – MOST RECENT TARGETED DMARD AND REASON FOR DISCONTINUATION

**Additional information regarding prior targeted DMARD trial(s) will be requested if required.**

| NAME, DOSE & FREQUENCY | APPROX. DURATION OF USE | FAILURE | | SIDE EFFECT(S) OR OTHER DETAILS - SPECIFY |
|---|---|---|---|---|
| | | TYPE I* | TYPE II** | |
| | | ◯ | ◯ | |

* Never achieving a 20% improvement

** At least 20% improvement in first 12 weeks of a TNF inhibitor (24 weeks for abatacept and rituximab) but loss of benefit

## 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 – CURRENT CLINICAL INFORMATION

| Year of Diagnosis of Rheumatoid Arthritis (YYYY) | Patient's Body Weight kg |
|---|---|
| | |

**PRE-TREATMENT CLINICAL ASSESSMENT (Not required if last baseline assessment was submitted less than 3 months ago)**

| *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 COMMENTS | DRUG | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**COMMENTS (optional):**

## SECTION 6 – CRITERIA FOR INITIAL COVERAGE (Please complete if this is the first application for a biologic)

Expectation for adequate dose/duration of DMARD trials; If a medication must be discontinued due to intolerance(s) prior to the expected duration of trial an alternate DMARD trial is required. Exceptions considered when additional DMARD trials cannot be attempted (supporting information must be provided for consideration).

| DMARD UTILIZATION | Duration of use | Reason for discontinuation | Describe AE or Other reason for discontinuation |
|---|---|---|---|
| ☐ **methotrexate (parenteral)** 25 mg (15 mg for over 65 years), minimum 8 weeks required | | ◯ Inadequate Response ◯ AE ◯ Other | |
| **PLUS at least one or more of the following (not including hydroxychloroquine)** | | | |
| ☐ a) **leflunomide** 20 mg daily for 10 weeks | | ◯ Inadequate Response ◯ AE ◯ Other | |
| ☐ b) **sulfasalazine** ≥ 2 gm daily for 3 months | | ◯ Inadequate Response ◯ AE ◯ Other | |
| ☐ c) **azathioprine** 2-3 mg/kg/day for 3 months | | ◯ Inadequate Response ◯ AE ◯ Other | |
| ☐ d) **other** – specify drug and dose (e.g. tacrolimus, cyclosporine, gold, doxycycline): | | ◯ Inadequate Response ◯ AE ◯ Other | |
| **PLUS at least one DMARD combination (NOTE: antimalarial in combination with one other DMARD is not acceptable)** | | | |
| ☐ a) methotrexate with hydroxychloroquine and sulfasalazine (O'Dell protocol), minimum 4 month trial | | ◯ Inadequate Response ◯ AE ◯ Other | |
| ☐ b) methotrexate with leflunomide, minimum 10 week trial | | ◯ Inadequate Response ◯ AE ◯ Other | |
| ☐ c) other – (specify drugs, duration): | | ◯ Inadequate Response ◯ AE ◯ Other | |

**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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