BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST
TARGETED DMARDs FOR RHEUMATOID ARTHRITIS
INITIAL / SWITCH

HLTH 5345 Rev. 2018/08/13

☐ **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 ☐ MAIL CONFIRMATION

☐ COLLEGE ID **OR** ☐ MSP NUMBER | PHONE NUMBER (INCLUDE AREA CODE)

CRITICAL FOR A TIMELY RESPONSE → | FAX NUMBER (INCLUDE AREA CODE)

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)*

Year of Diagnosis of Rheumatoid Arthritis (YYYY) _____

Patient's Body Weight _____ kg

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

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

☐ **ETANERCEPT: BRENZYS™** 50 mg
☐ **ETANERCEPT: ERELZI™** 25, 50 mg
50 mg weekly

☐ **GOLIMUMAB**
50 mg SC once per month in combination with
- ☐ Methotrexate
- ☐ Other (specify):

☐ **INFLIXIMAB: INFLECTRA™**
☐ **INFLIXIMAB: RENFLEXIS™**
3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Infliximab in combination with
- ☐ Methotrexate
- ☐ Other (specify):

☐ **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 with methotrexate (or without methotrexate in cases of methotrexate intolerance)

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

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:

☐ Health Assessment Questionnaire (HAQ) completed by patient and attached

CONCURRENT DMARD THERAPY: OR ☐ MARK HERE IF NONE	DRUG	DOSE	ROUTE	FREQUENCY

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

DMARD UTILIZATION	INDICATE AND SPECIFY ALL THAT APPLY TO THE PATIENT'S DMARD UTILIZATION		
	Lack of Effect	Intolerance/Side Effect(s)	Contraindications
☐ **methotrexate** parenteral 25 mg (15 mg for over 65 years), minimum 8 weeks required			
PLUS two or more of the following – required			
☐ a) **leflunomide** 20 mg daily for 10 weeks			
☐ b) **gold** weekly injections for 20 weeks			
☐ c) **sulfasalazine** ≥ 2 gm daily for 3 months			
☐ d) **azathioprine** 2-3 mg/kg/day for 3 months			
☐ e) **other** – specify drug, dose, duration			
☐ f) **other** – specify drug, dose, duration			
PLUS at least one DMARD combination (NOTE: antimalarial in combination with one other DMARD is not acceptable)			
☐ a) methotrexate with cyclosporine minimum 4 months			
☐ b) methotrexate with hydroxychloroquine and sulfasalazine (O'Dell protocol), minimum 4 months			
☐ c) methotrexate with gold, minimum 20 week trial			
☐ d) methotrexate with leflunomide, minimum 10 week trial			
☐ e) other – specify drugs, duration			

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, used and disclosed under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* and *Freedom of Information and Protection of Privacy Act*. It will not be disclosed to any persons without the patient's consent.The information you provide will be relevant to and used solely to (a) provide PharmaCare benefits for the medication requested, (b) to implement, monitor and evaluate this and other Ministry programs, and (c) to manage and plan for the health system generally. If you have any questions about the collection or use 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.

PRINT CLEAR FORM