



SPECIAL AUTHORITY REQUEST TARGETED DMARDs FOR RHEUMATOID ARTHRITIS INITIAL / SWITCH

HLTH 5345 Rev. 2018/03/23

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

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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, MSP number, phone number, fax number, critical for a timely response

SECTION 2 - PATIENT INFORMATION

Patient (family) name, patient (given) name(s), date of birth, date of application, personal health number, critical for processing

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

Year of diagnosis, patient's body weight, initial one year coverage for moderately to severely active rheumatoid arthritis, medication options: Abatacept, Adalimumab, Certolizumab, Etanercept, Golimumab, Infliximab, Tocilizumab, Tofacitinib

SECTION 4 - MOST RECENT TARGETED DMARD AND REASON FOR DISCONTINUATION

Table with columns: Name, Dose & Frequency, Approx. Duration of Use, Failure Type I, Failure Type II, Side Effect(s) or Other Details - Specify

* 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

SECTION 5 – CURRENT CLINICAL INFORMATION

PRE-TREATMENT CLINICAL ASSESSMENT (Not required if last baseline assessment was submitted less than 3 months ago)						
<small>68 JOINT COUNT:</small>	No. of Swollen Joints	No. of Tender Joints	ESR	or	CRP	Duration of Morning Stiffness
						Dose of Prednisone
Physician Overall Assessment of Inflammation <small>(scale of 0 -10), 0 = remission, 10 = severe active disease:</small>			<input type="checkbox"/> Health Assessment Questionnaire (HAQ) completed by patient and attached			
CONCURRENT DMARD THERAPY:		DRUG	DOSE	ROUTE	FREQUENCY	
OR						
<input type="checkbox"/> MARK HERE IF NONE						

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
<input type="checkbox"/> methotrexate <small>parenteral 25 mg (15 mg for over 65 years), minimum 8 weeks required</small>			
PLUS two or more of the following – required			
<input type="checkbox"/> a) leflunomide <small>20 mg daily for 10 weeks</small>			
<input type="checkbox"/> b) gold <small>weekly injections for 20 weeks</small>			
<input type="checkbox"/> c) sulfasalazine <small>≥ 2 gm daily for 3 months</small>			
<input type="checkbox"/> d) azathioprine <small>2-3 mg/kg/day for 3 months</small>			
<input type="checkbox"/> e) other – specify drug, dose, duration			
<input type="checkbox"/> f) other – specify drug, dose, duration			
PLUS at least one DMARD combination (NOTE: antimalarial in combination with one other DMARD is not acceptable)			
<input type="checkbox"/> a) methotrexate with cyclosporine <small>minimum 4 months</small>			
<input type="checkbox"/> b) methotrexate with hydroxychloroquine and sulfasalazine (O'Dell protocol), <small>minimum 4 months</small>			
<input type="checkbox"/> c) methotrexate with gold, <small>minimum 20 week trial</small>			
<input type="checkbox"/> d) methotrexate with leflunomide, <small>minimum 10 week trial</small>			
<input type="checkbox"/> 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.