



INITIAL Complete sections 1, 2, 3 & 4

RENEWAL Complete sections 1, 2, 3 & 5

SWITCH Complete sections 1, 2, 3 & 6

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-Patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited. If you have received this fax in error, please write "MIS-DIRECTED" across the front of the form and fax toll-free to 1 800 609-4884, then destroy the pages received in error.

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 - NEUROLOGIST'S INFORMATION

Form for Neurologist's Information including fields for Name, Address, Mail Confirmation, College ID, MSP Number, Phone Number, and Fax Number.

SECTION 2 - PATIENT INFORMATION

Form for Patient Information including fields for Family Name, Given Name(s), Date of Birth, Date of Application, and Personal Health Number (PHN).

SECTION 3 - MEDICATION REQUESTED

Form for Medication Requested with checkboxes for Interferon Beta-1A (Avonex), Interferon Beta-1B (Betaseron, Extavia), Dimethyl Fumarate (Tecfidera), Interferon Beta-1A (Rebif), Glatiramer Acetate (Copaxone), and Teriflunomide (Aubagio).

SECTION 4 - INITIAL COVERAGE CRITERIA

Form for Initial Coverage Criteria with checkboxes for monotherapy criteria, neurologist prescription, and specific clinical criteria like EDSS score and attack history.

PHARMACARE USE ONLY

Please complete additional information on page 2 >>

Table for Pharmacist Use Only with columns for STATUS, EFFECTIVE DATE (YYYY / MM / DD), and DURATION OF APPROVAL.

PATIENT NAME	PHN	DATE (YYYY / MM / DD)
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**SECTION 5 – RENEWAL COVERAGE CRITERIA**

- As monotherapy for the treatment of relapsing-remitting multiple sclerosis, OR, for Interferon Beta-1B, as monotherapy for secondary progressive multiple sclerosis.
- Prescribed by a neurologist from a designated multiple sclerosis clinic.
- The patient has had continued therapeutic benefit since the initiation of disease modifying therapy, outweighing any potential risks.

**PLUS** evidence of continued benefit (improvement or stabilization) as shown by at least ONE of the following:

- A.  Reduction in relapse rate (decrease from \_\_\_\_\_ relapses per year to \_\_\_\_\_ relapses per year).
- B.  Improvement or stability of EDSS score. Most recent EDSS score \_\_\_\_\_ date \_\_\_\_\_  
Previous EDSS score \_\_\_\_\_ date \_\_\_\_\_
- C.  MRI scan: Reduction or stability in lesion load.
- D.  MRI scan: Reduction in gadolinium enhancing lesions.
- E.  Overall clinical impression of benefit (provide details):

**SECTION 6 – CHANGE OF THERAPY CRITERIA****A. MEDICATION TO BE DISCONTINUED**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> <b>INTERFERON BETA-1A<br/>(AVONEX)</b><br>30 MCG IM ONCE WEEKLY            | <input type="checkbox"/> <b>INTERFERON BETA-1B<br/>(BETASERON, EXTAVIA)</b><br>250 MCG SC EVERY OTHER DAY | <input type="checkbox"/> <b>DIMETHYL FUMARATE<br/>(TECFIDERA)</b><br>120 - 240 MG PO TWICE DAILY |
| <input type="checkbox"/> <b>INTERFERON BETA-1A<br/>(REBIF)</b><br>22-44 MCG SC THREE TIMES PER WEEK | <input type="checkbox"/> <b>GLATIRAMER ACETATE<br/>(COPAXONE)</b><br>20 MG SC DAILY                       | <input type="checkbox"/> <b>TERIFLUNOMIDE<br/>(AUBAGIO)</b><br>14 MG PO ONCE DAILY               |

**B. CRITERIA FOR CHANGE IN MEDICATION**

- As monotherapy for the treatment of relapsing-remitting multiple sclerosis, OR, for Interferon Beta-1B, as monotherapy for secondary progressive multiple sclerosis.
- Prescribed by a neurologist from a designated multiple sclerosis clinic.
- Evidence of failure or intolerance as show by at least ONE of the following (please check all that apply):
- Lack of effectiveness
  - Injection site reactions
  - Flu-like symptoms
  - Other (please specify):

**SECTION 7 – PRESCRIBER'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.

\_\_\_\_\_  
Prescriber'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.

**Report all adverse events to Canada Vigilance toll-free 1-866-234-2345 (health professionals only).**