BRITISH COLUMBIA | Ministry of Health

*SPECIAL AUTHORITY REQUEST*

# DISEASE MODIFYING DRUGS FOR MULTIPLE SCLEROSIS

**Interferon Beta-1A (Avonex), Interferon Beta-1A (Rebif), Interferon Beta-1B (Betaseron, Extavia), Rituximab, Glatiramer Acetate (Glatect), Dimethyl Fumarate (Tecfidera), Teriflunomide (Aubagio)**

HLTH 5351 2018/11/28

☐ **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

Prescriber's Name and Mailing Address ☐ Mail Confirmation

☐ College ID **OR** ☐ MSP Number

Phone Number (include area code)

**CRITICAL FOR A TIMELY RESPONSE** →

Neurologist'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

☐ **INTERFERON BETA-1A (AVONEX)**
30 MCG IM ONCE WEEKLY

☐ **INTERFERON BETA-1A (REBIF)**
22-44 MCG SC THREE TIMES PER WEEK

☐ **INTERFERON BETA-1B (BETASERON, EXTAVIA)**
250 MCG SC EVERY OTHER DAY

☐ **GLATIRAMER ACETATE (GLATECT)**
20 MG SC DAILY

☐ **DIMETHYL FUMARATE (TECFIDERA)**
120 - 240 MG PO TWICE DAILY

☐ **TERIFLUNOMIDE (AUBAGIO)**
14 MG PO ONCE DAILY

☐ **RITUXIMAB**

**INITIAL COVERAGE, TWO COURSES**
1000 MG AT 0 & 2 WEEKS, FOLLOWED BY 1000 MG A MINIMUM 24 WEEKS AFTER.

**RENEWAL, TWO COURSES**
EACH COURSE IS 1000 MG, MINIMUM 24 WEEKS BETWEEN COURSES.

## SECTION 4 – INITIAL COVERAGE CRITERIA

☐ As monotherapy for the treatment of relapsing-remitting multiple sclerosis, diagnosed according to the 2010 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, OR, for Interferon Beta-1B, as monotherapy for secondary progressive multiple sclerosis.

☐ Prescribed by a neurologist from a designated multiple sclerosis clinic.

Most recent EDSS score _____ , date _____ .

**PLUS for patients meeting all of the following:**

☐ At least two (2) attacks of multiple sclerosis during the previous two (2) years (an attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 24 hours in the absence of fever, and preceded by stability for at least one month), AND

☐ Ambulatory without or with aid (EDSS 6.5 or less), AND

☐ 18 years of age or older.

**Please complete additional information on page 2 >>**

## PHARMACARE USE ONLY

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

# DISEASE MODIFYING DRUGS FOR MULTIPLE SCLEROSIS

| PATIENT NAME | PHN | DATE (YYYY / MM / DD) |
|---|---|---|
| | | |

## 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

☐ **INTERFERON BETA-1A (AVONEX)**
30 MCG IM ONCE WEEKLY

☐ **INTERFERON BETA-1A (REBIF)**
22-44 MCG SC THREE TIMES PER WEEK

☐ **INTERFERON BETA-1B (BETASERON, EXTAVIA)**
250 MCG SC EVERY OTHER DAY

☐ **GLATIRAMER ACETATE (GLATECT)**
20 MG SC DAILY

☐ **DIMETHYL FUMARATE (TECFIDERA)**
120 - 240 MG PO TWICE DAILY

☐ **TERIFLUNOMIDE (AUBAGIO)**
14 MG PO ONCE DAILY

☐ **RITUXIMAB**
**INITIAL COVERAGE, TWO COURSES**
1000 MG AT 0 & 2 WEEKS, FOLLOWED BY 1000 MG A MINIMUM 24 WEEKS AFTER.
**RENEWAL, TWO COURSES**
EACH COURSE IS 1000 MG, MINIMUM 24 WEEKS BETWEEN COURSES.

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).**

PRINT CLEAR FORM