BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

TARGETED DMARDS FOR PSORIATIC ARTHRITIS

INITIAL / SWITCH

HLTH 5360 Rev. 2018/08/13

☐ **INITIAL**
Complete sections 1 – 3, 5

☐ **SWITCH**
Complete sections 1 – 4, 5A – 5C

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 – RHEUMATOLOGIST INFORMATION

PRESCRIBER'S NAME AND MAILING ADDRESS ☐ MAIL CONFIRMATION

☐ COLLEGE ID **OR** ☐ MSP NUMBER

PHONE NUMBER (INCLUDE AREA CODE)

CRITICAL FOR A TIMELY RESPONSE →

PRESCRIBER'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 – CURRENT CLINICAL INFORMATION

MEDICATION REQUESTED

☐ **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**
25 mg twice weekly or 50 mg weekly

☐ **GOLIMUMAB**
50 mg SC once per month

INFLIXIMAB
3-5 mg/kg at 0, 2, and 6 weeks then every 8 weeks thereafter

☐ **INFLECTRA™**

☐ **RENFLEXIS™**

☐ **SECUKINUMAB**
☐ 150 MG ☐ 300 MG
At weeks 0, 1, 2, 3, and 4 followed by monthly maintenance dosing. 300 mg dosing considered if prior anti-TNF failure with ongoing active psoriatic arthritis, or if patient has coexistent moderate to severe plaque psoriasis

YEAR OF DIAGNOSIS OF PSORIATIC ARTHRITIS	WEIGHT (KG)	ESR or CRP	MORNING STIFFNESS (MINUTES)	PHYSICIAN GLOBAL ASSESSMENT OF ***INFLAMMATION*** (SCALE OF 0-10, 0=NONE, 10=SEVERE ACTIVE DISEASE)

CURRENT MEDICATIONS (DMARDs, anti-inflammatories, corticosteroids, analgesics, opioids)

DRUG	DOSE	FREQUENCY

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

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE	DURATION OF THERAPY / TERMINATION DATE

PATIENT NAME	PHN	DATE (YYYY / MM / DD)

SECTION 5 - CRITERIA FOR COVERAGE OF ONE YEAR – Patient must meet criteria in A, B, C and D below

A Current Status Of Cutaneous Psoriasis: ☐ none ☐ mild ☐ moderate ☐ severe

B ☐ Diagnosis of moderate to severe psoriatic arthritis, where patient currently exhibits at least **two** of the following (please indicate all that apply):

- ☐ Five or more active joints **(if yes, complete homunculus below)**.
- ☐ If oligoarticular (less than five joints), at least one active joint proximal to, or including, wrist or ankle **(if yes, complete homunculus below)**.
- ☐ More than one joint with erosion on imaging study.
- ☐ Dactylitis of two or more digits **(indicate by arrow and "D" on homunculus below)**.
- ☐ Tenosynovitis refractory to oral NSAIDs AND steroid injections **(indicate by arrow and "TS" on homunculus below)**.
- ☐ Enthesitis refractory to oral NSAIDs AND steroid injections (not required for Achilles tendon) **(indicate by arrow and "E" on homunculus below)**.
- ☐ Inflammatory spinal symptoms refractory to two NSAIDs (minimum 4 week trial each) and submit a BASDAI with a score greater than 4.
- ☐ Daily use of corticosteroids to control active arthritis.
- ☐ Use of narcotics >12 hours per day for pain resulting from inflammation.

Specify drug and daily dose _____

C ☐ Functional assessment completed by patient and attached.

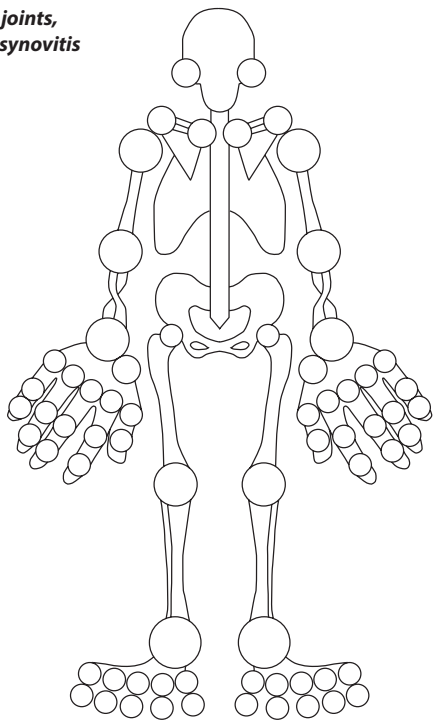
☐ Health Assessment Questionnaire (HAQ) **AND/OR** ☐ BASDAI (in spinal disease)

D ☐ Patient has failed two or more DMARDs:

	DOSE	FREQUENCY	DURATION	RESPONSE/ADVERSE EVENT
☐ Sulfasalazine (if allergic, must have failed **two** of the medications listed below).				
☐ Methotrexate: up to 25 mg (15 mg if over 65 years) parenteral weekly				
☐ IM gold				
☐ Chloroquine and/or hydroxychloroquine				
☐ Leflunomide				
☐ Cyclosporine				
☐ Other (specify)				

HOMUNCULUS

Indicate active joints, dactylitis, tenosynovitis and enthesitis



Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).

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 RESET