



INITIAL Complete sections 1-3, 5, plus 6-7 if applicable

SWITCH Complete sections 1 - 4, 5A-5B, plus 6 if applicable

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 you have received this fax in error, please write MISDIRECTED 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 - SPECIALIST INFORMATION

Name and Mailing Address, College ID, Phone Number, Rheumatologist's 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 (PHN), CRITICAL FOR PROCESSING

SECTION 3 - CURRENT CLINICAL INFORMATION

MEDICATION REQUESTED: ADALIMUMAB, GOLIMUMAB, INFLIXIMAB, AVSOLA, INFLECTRA, RENFLEXIS, CERTOLIZUMAB, SECUKINUMAB, ETANERCEPT, BRENZYS, ERELZI, RYMTI

YEAR OF DIAGNOSIS OF ANKYLOSING SPONDYLITIS, WEIGHT (KG), ESR or CRP, MORNING STIFFNESS (MINUTES), PHYSICIAN GLOBAL ASSESSMENT OF INFLAMMATION

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

Table with columns: MEDICATION, 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. 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

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

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

PATIENT NAME	PHN
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**SECTION 5 - CRITERIA FOR COVERAGE OF ONE YEAR**

Patient must meet criteria in A, B, and C below.

**A**  Diagnosis of moderate to severe ankylosing spondylitis. Complete **all** that apply:

Extra-articular manifestations. Specify:  uveitis  IBD  psoriasis  other: \_\_\_\_\_

**AXIAL DISEASE**

Positive imaging finding of ankylosing spondylitis. Changes seen: \_\_\_\_\_ Imaging method used: \_\_\_\_\_  
If no positive imaging, please provide HLA B27 status and spondyloarthropathy features in Section 7 below.

Presence of spinal pain. Specify degree of spinal pain:  Mild  Moderate  Severe

**PERIPHERAL DISEASE**

Active joints (complete homunculus below)  Active Tenosynovitis and/or Enthesitis (indicate by arrow and "TS" or "E" on homunculus as applicable)

**B**  Active ankylosing spondylitis with a BASDAI score ≥ 4. Copy of BASDAI attached.  Copy of HAQ attached if predominantly peripheral disease.

**C** For predominantly axial disease, treatment failure or intolerance to two NSAIDs for a minimum of two weeks each at accepted maximum daily dosage, examples: naproxen 1000-1500 mg, ibuprofen 1800-2400 mg, diclofenac 100 mg, celecoxib 200 mg, meloxicam 15 mg, indomethacin 150 mg, flurbiprofen 200 mg

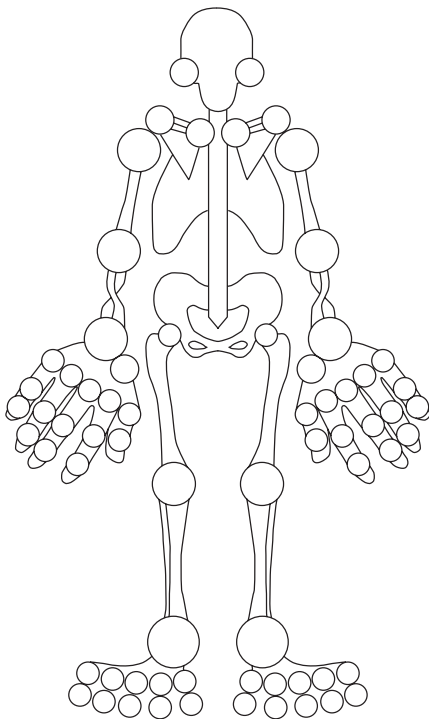
Specify the two NSAIDs tried:	DOSE	FREQUENCY	DURATION	RESPONSE / ADVERSE EVENT

**OR**, for predominantly peripheral disease, patient is refractory to minimum 3 month trials of each of the following:

	DOSE	FREQUENCY	DURATION	RESPONSE / ADVERSE EVENT
1. <input type="checkbox"/> Methotrexate up to 25 mg (15 mg over 65 years) parenteral weekly				
2. <input type="checkbox"/> Sulfasalazine up to 3g daily				

**SECTION 6 – HOMUNCULUS**

Indicate active joints, tenosynovitis and enthesitis.



**SECTION 7 – SPONDYLOARTHROPATHY (SpA) FEATURES**

If no positive imaging, please confirm patient is HLA B27+ and provide at least two additional SpA features below.

**Confirmation Patient is HLA B27+. Two additional SpA features also required.**

Additional SpA Features:

- |                                                 |                                     |                                                  |
|-------------------------------------------------|-------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> inflammatory back pain | <input type="checkbox"/> dactylitis | <input type="checkbox"/> good response to NSAIDs |
| <input type="checkbox"/> arthritis              | <input type="checkbox"/> psoriasis  | <input type="checkbox"/> family history for SpA  |
| <input type="checkbox"/> enthesitis             | <input type="checkbox"/> IBD        | <input type="checkbox"/> elevated CRP            |
| <input type="checkbox"/> uveitis                |                                     |                                                  |

**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 under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act 22(1)* and *Freedom of Information and Protection of Privacy Act 26 (a),(c),(e)*.

The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection 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.*