BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

TARGETED DMARDS FOR ANKYLOSING SPONDYLITIS
INITIAL / SWITCH

☐ **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 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

Rheumatologist's Name and Mailing Address ☐ Mail Confirmation	
☐ College ID **OR** ☐ MSP Number	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Rheumatologist'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	☐ **ETANERCEPT: BRENZYS™** 50 mg ☐ **ETANERCEPT: ERELZI™** 25, 50 mg 50 mg weekly	☐ **INFLIXIMAB: INFLECTRA™** ☐ **INFLIXIMAB: RENFLEXIS™** 3-5 mg/kg at 0, 2, and 6 weeks then every 8 weeks thereafter
☐ **CERTOLIZUMAB** 400 mg at 0, 2, and 4 weeks, followed by 200 mg every other week or 400 mg every 4 weeks	☐ **GOLIMUMAB** 50 mg SC once per month	☐ **SECUKINUMAB** 150 mg at weeks 0, 1, 2, 3, and 4 followed by monthly maintenance dosing.

YEAR OF DIAGNOSIS OF ANKYLOSING SPONDYLITIS	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)

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.

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 (YYYY / MM / DD)	DURATION OF APPROVAL

TARGETED DMARDS FOR ANKYLOSING SPONDYLITIS

PATIENT NAME	PHN

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: _____

☐ **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 three NSAIDS for a minimum of two weeks each at accepted maximum dosage:

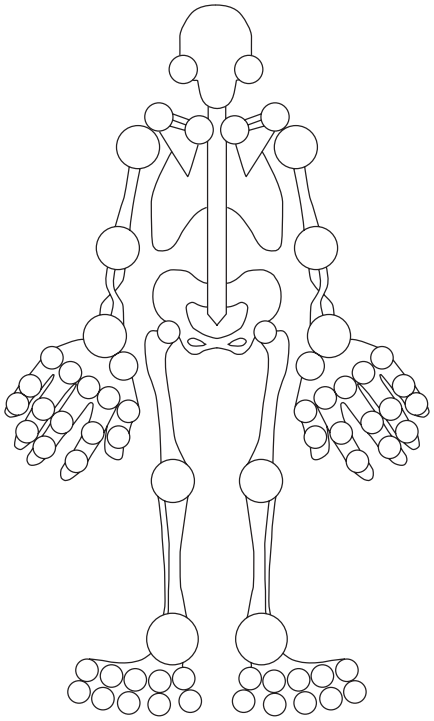
Specify the three NSAIDs tried:	DOSE	FREQUENCY	DURATION	RESPONSE / ADVERSE EVENT

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. ☐ Methotrexate up to 25 mg (15 mg over 65 years) parenteral weekly				
2. ☐ 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+

Additional SpA Features:

☐ inflammatory back pain
☐ arthritis
☐ enthesitis
☐ uveitis
☐ dactylitis
☐ psoriasis
☐ Crohn's / colitis
☐ good response to NSAIDs
☐ family history for SpA
☐ elevated CRP

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