BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

TARGETED DMARDs FOR ANKYLOSING SPONDYLITIS
RENEWAL / DOSING ADJUSTMENT

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 privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

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.

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.

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 (use ONLY College ID 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 – MEDICATION REQUESTED

Requested Dose and Interval

_____ mg, every: _____

Patient's Body Weight (if significantly changed)

_____ kg

◯ **ADALIMUMAB:** 40 mg every two weeks
- ◯ **Indefinite coverage**
- **OR** ◯ **Renewal of three years**
- **OR** ◯ **Renewal of one year**

◯ **ABRILADA®** ◯ **AMGEVITA®** ◯ **HADLIMA®** ◯ **HULIO®**
◯ **HYRIMOZ®** ◯ **IDACIO®** ◯ **SIMLANDI™** ◯ **YUFLYMA®**

◯ **CERTOLIZUMAB:** 200 mg every other week or 400 mg every 4 weeks
- ◯ **Indefinite coverage**
- **OR** ◯ **Renewal of three years**
- **OR** ◯ **Renewal of one year**

◯ **ETANERCEPT:** total dose of 50 mg weekly
- ◯ **Indefinite coverage**
- **OR** ◯ **Renewal of three years**
- **OR** ◯ **Renewal of one year**

◯ **BRENZYS®** 50 mg ◯ **ERELZI®** 25, 50 mg ◯ **RYMTI®** 50 mg

◯ **GOLIMUMAB:** 50 mg SC. once per month
- ◯ **Renewal of one year**

◯ **INFLIXIMAB:** 3-5 mg/kg every 8 weeks
- ◯ **Indefinite coverage**
- **OR** ◯ **Renewal of three years**
- **OR** ◯ **Renewal of one year**

◯ **AVSOLA®** ◯ **INFLECTRA®** ◯ **RENFLEXIS®**

◯ **SECUKINUMAB:** 150 mg monthly
- ◯ **Renewal of one year**

If approved, please note that claims with indefinite SA approvals will be monitored and any overuse or significant underuse will be subject to review.

SECTION 4 – CURRENT CLINICAL INFORMATION

ESR or CRP	MORNING STIFFNESS (MINUTES)	PHYSICIAN GLOBAL ASSESSMENT OF **INFLAMMATION** (SCALE OF 0 - 10), 0 = REMISSION, 10 = SEVERE ACTIVE DISEASE)	

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

MEDICATION	DOSE	FREQUENCY

SECTION 6 - CRITERIA FOR RENEWAL (For the criteria **originally specified** on intial coverage form, please provide current status)

Please complete all sections below

RESPONSE TO THERAPY COMPARED TO BASELINE

☐ **Extra-articular manifestations** (specify even if resolved): ◯ Worsened ◯ No Response ◯ Improved ◯ Resolved

☐ uveitis ☐ IBD ☐ psoriasis ☐ other: _____

☐ **AXIAL DISEASE**

☐ Spinal pain ◯ Worsened ◯ No Response ◯ Improved ◯ Resolved

☐ **PERIPHERAL DISEASE**

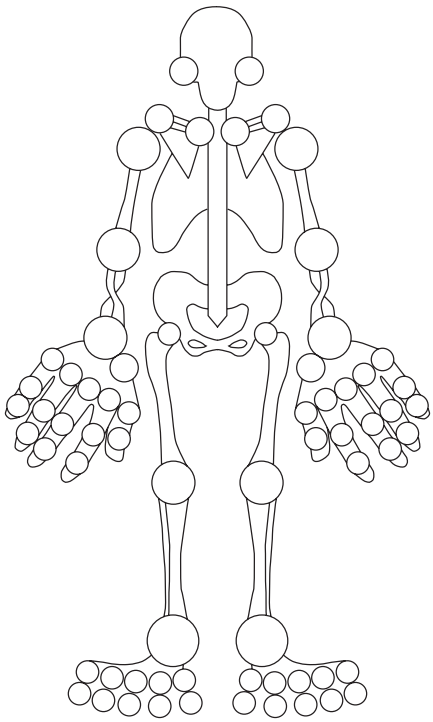
☐ Active joints (complete homunculus below) ◯ Worsened ◯ No Response ◯ Improved ◯ Resolved

☐ Active tenosynovitis and/or enthesitis (indicate by arrow and "TS" or "E" on homunculus as applicable) ◯ Worsened ◯ No Response ◯ Improved ◯ Resolved

☐ Copy of a current BASDAI attached. ☐ Copy of HAQ attached if predominantly peripheral disease.

ADDITIONAL COMMENTS REGARDING PATIENT'S CURRENT MEDICAL STATUS

SECTION 7 - HOMUNCULUS *Indicate active joints, 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 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.

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