BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

ADALIMUMAB / INFLIXIMAB / VEDOLIZUMAB FOR MODERATE TO SEVERE ACTIVE CROHN'S / FISTULIZING CROHN'S DISEASE

HLTH 5368 Rev. 2018/08/14

☐ **INITIAL COVERAGE (Complete sections 1 - 6, and 9)** ☐ **RENEWAL COVERAGE (Complete sections 1 - 4, 8 and 9)**

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 – PRESCRIBING GASTROENTEROLOGIST'S INFO.

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 – MEDICATION REQUESTED AND CLINICAL INFORMATION

INDUCTION	☐ **INFLIXIMAB (INFLECTRA™)(3 DOSES)** ☐ **INFLIXIMAB (RENFLEXIS™) (3 DOSES)** 5MG/KG AT 0, 2, AND 6 WEEKS	☐ **ADALIMUMAB (12 WEEK SUPPLY)** 160 MG WK 0, 80 MG WK 2, THEN 40 MG WKS 4, 6, 8, AND 10	☐ **VEDOLIZUMAB (3 DOSES)** 300 MG AT 0, 2, AND 6 WEEKS	CURRENT WEIGHT IN KG
RENEWAL	☐ **INFLIXIMAB (INFLECTRA™) (1 YEAR)** ☐ **INFLIXIMAB (RENFLEXIS™) (1 YEAR)** 5MG/KG EVERY 8 WEEKS	☐ **INFLIXIMAB (REMICADE®) (1 YEAR)** 5MG/KG EVERY 8 WEEKS	☐ **ADALIMUMAB (1 YEAR)** 40 MG EVERY 2 WEEKS ☐ **VEDOLIZUMAB (1 YEAR)** 300 MG EVERY 8 WEEKS	CURRENT STEROID DOSE

DIAGNOSIS ☐ MODERATE TO SEVERE ACTIVE CROHN'S ☐ FISTULIZING CROHN'S

YEAR OF CROHN'S DIAGNOSIS

IMPACT OF CURRENT CONDITION ON WORK/SOCIAL LIFE ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

EXTRAINTESTINAL MANIFESTATIONS ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

SPECIFY EXTRAINTESTINAL MANIFESTATIONS

SECTION 4 – CONCURRENT THERAPY

INCLUDE ALL antidiarrheals, narcotics, immunosuppressants, antibiotics

	DRUG, DOSE/ROUTE, FREQUENCY
1	
2	
3	
4	

SECTION 5 – INITIAL DIAGNOSTIC INFORMATION

FOR MODERATE TO SEVERE CROHN'S

SITE OF CROHN'S ☐ ISOLATED COLONIC ☐ ILEAL COLONIC ☐ SMALL BOWEL ☐ OTHER (SPECIFY)

CURRENT **HARVEY BRADSHAW INDEX** (HBI ≥ 8)

FOR FISTULIZING CROHN'S

SITE OF FISTULA(E) ☐ PERIANAL ☐ ENTEROCUTANEOUS ☐ RECTO-VAGINAL ☐ OTHER (SPECIFY)

NUMBER OF FISTULAE

FISTULA DRAINAGE AND BLEEDING ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

PAIN AT FISTULA SITES ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

Continued on page 2 >>

PHARMACARE USE ONLY

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

PATIENT NAME	PHN	DATE (YYYY / MM / DD)

SECTION 6 – PRIOR MEDICATION THERAPY (INITIAL COVERAGE)

FOR PATIENTS WITH MODERATE TO SEVERE ACTIVE CROHNS

Details of glucocorticoid trial

☐ corticosteroid resistant: lack of a symptomatic response despite a course of oral prednisone 40-60mg/day (or equivalent) for a minimum of 14 days.

☐ corticosteroid dependent: unable to withdraw oral corticosteroid within 3 months of initiation without a recurrence of symptoms; a symptomatic relapse within 3 months of stopping; or the need for two or more courses of corticosteroids within one year.

☐ corticosteroid use is contraindicated (specify): _____

☐ intolerant/side effect(s) (specify): _____

Details of other medication trial(s)

Drug Name, Dose, Duration	Details of Outcome (Failure, Contraindication, Intolerance, Other)
	☐ Lack of Effect ☐ Contraindication ☐ Intolerance ☐ Other Specify:

FOR PATIENTS WITH FISTULIZING CROHNS

Drug Name, Dose, Duration	Details of Outcome (Failure, Contraindication, Intolerance, Other)
☐ **Ciprofloxacin** at maximally tolerated doses (min 3 week trial) ☐ **Metronidazole** at maximally tolerated doses (min 3 week trial)	☐ Lack of Effect ☐ Contraindication ☐ Intolerance ☐ Other Specify:

SECTION 7 – ADDITIONAL INFORMATION, IF APPLICABLE

FECAL CALPROTECTIN	CRP	ESR	DRUG LEVEL

SECTION 8 – RENEWAL COVERAGE

MODERATE TO SEVERE ACTIVE CROHN'S
DURATION OF RESPONSE IF PATIENT FLARING BEFORE NEXT DOSE
CURRENT **HARVEY BRADSHAW INDEX** SCORE WHILE ON TREATMENT (REQUIRES HBI SCORE ≤5 OR A DECREASE IN SCORE ≥4)

FISTULIZING CROHN'S: SYMPTOMS WHILE ON TREATMENT	
DURATION OF RESPONSE IF PATIENT FLARING BEFORE NEXT DOSE	
NUMBER OF FISTULAE:	FISTULA RESPONSE TO TREATMENT ☐ WORSE ☐ NONE ☐ MODERATE ☐ RESOLVED
FISTULA DRAINAGE AND BLEEDING ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE	PAIN AT FISTULA SITE ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

SECTION 9 – PRESCRIBER 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.

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