



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 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.

Form for Section 1 containing fields for Name and Mailing Address, Mail Confirmation, College ID, MSP Number, Phone Number, and Prescriber's Fax Number.

SECTION 2 - PATIENT INFORMATION

Form for Section 2 containing fields for Patient (Family) Name, Patient (Given) Name(s), Date of Birth, Date of Application, and Personal Health Number (PHN).

SECTION 3 - MEDICATION REQUESTED AND CLINICAL INFORMATION

Form for Section 3 containing medication options (Induction and Renewal), current weight, current steroid dose, diagnosis, and extraintestinal manifestations.

SECTION 4 - CONCURRENT THERAPY

INCLUDE ALL antidiarrheals, narcotics, immunosuppressants, antibiotics

Table for Section 4 with 4 rows for listing concurrent therapy (Drug, Dose/Route, Frequency).

SECTION 5 - INITIAL DIAGNOSTIC INFORMATION

Form for Section 5 containing diagnostic information for Moderate to Severe Crohn's and Fistulizing Crohn's, including site of disease and Harvey Bradshaw Index.

PHARMACARE USE ONLY

Continued on page 2 >>

Form for Pharmacare Use Only containing fields for Status, Effective Date, and Duration of Approval.

PATIENT NAME	PHN	DATE (YYYY / MM / DD)
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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)
	<input type="checkbox"/> Lack of Effect <input type="checkbox"/> Contraindication <input type="checkbox"/> Intolerance <input type="checkbox"/> Other Specify: _____

FOR PATIENTS WITH FISTULIZING CROHNS

Drug Name, Dose, Duration	Details of Outcome (Failure, Contraindication, Intolerance, Other)
<input type="checkbox"/> Ciprofloxacin at maximally tolerated doses (min 3 week trial)	<input type="checkbox"/> Lack of Effect <input type="checkbox"/> Contraindication <input type="checkbox"/> Intolerance <input type="checkbox"/> Other Specify: _____
<input type="checkbox"/> Metronidazole at maximally tolerated doses (min 3 week trial)	

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 <input type="checkbox"/> WORSE <input type="checkbox"/> NONE <input type="checkbox"/> MODERATE <input type="checkbox"/> RESOLVED
FISTULA DRAINAGE AND BLEEDING <input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE	PAIN AT FISTULA SITE <input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> 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.