BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

CHRONIC HEPATITIS B

HLTH 5372 Rev. 2019/05/21

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 – PRESCRIBER INFORMATION

Prescriber's 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 – INITIAL COVERAGE

3.1 LAMIVUDINE, TENOFOVIR (VIREAD TYPE) OR ENTECAVIR – DURATION OF COVERAGE: INDEFINITE

Requested Medication (select ONE of the following medications):

☐ **LAMIVUDINE: 9901-0163** ☐ **TENOFOVIR (VIREAD TYPE): 9901-0182** ☐ **ENTECAVIR: 9901-0089**

☐ Confirmed chronic Hepatitis B (HBsAg Positive for at least 6 months)

☐ Patient meets at least ONE of the following criteria **(complete Section A or B as appropriate):**

SECTION A	DATE (YYYY/MM/DD)	VALUE	ULN
☐ HBV DNA > 2000 IU/mL **AND**		(IU/mL)	
☐ ALT level > 1 x ULN		(U/L)	(U/L)

SECTION B	DATE (YYYY/MM/DD)	VALUE
☐ Fibrosis stage ≥ F2*. Supporting evidence is attached. *(*Acceptable methods of evaluation : liver biopsy /Fibroscan (preferred) or APRI)*		

3.2 INTERFERON ALFA

All requests will be reviewed by the adjudication committee. Please provide evidence for use and submit additional document(s) to support request, as applicable.

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.

PHARMACARE USE ONLY

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

continued on page 2 →

CHRONIC HEPATITIS B

Patient Name	PHN

SECTION 4 – INITIAL COVERAGE, LAMIVUDINE RESISTANCE AND/OR ADEFOVIR EXPERIENCED WITH PERSISTENT VIREMIA

TENOFOVIR – DURATION OF COVERAGE: INDEFINITE

☐ **TENOFOVIR (VIREAD TYPE): 9901-0182**

		DATE (YYYY/MM/DD)	VALUE
☐ **Previously on lamivudine for at least 3 months**			
AND ☐ Compliant with medications			
AND ☐ Failure on lamivudine defined as HBV DNA ≥ 1 log IU/mL above nadir, measured on two (2) separate occasions at least 1 month apart.	nadir		(IU/mL)
	1st HBV DNA level		(IU/mL)
	2nd HBV DNA level		(IU/mL)
OR ☐ Adefovir experienced with persistent viremia and lamivudine resistance.			

SECTION 5 – ADDITIONAL COMMENTS (IF APPLICABLE)

If the above criteria are not met, please provide the following information: medication requested, indication for treatment and submit additional information/ document(s) to support request (e.g. hepatitis B serology, viral load, fibrosis stage report, etc). ***Please provide details, as applicable:***

SECTION 6 – PRESCRIBER'S 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)

Report all adverse events to Canada Vigilance toll-free 1-866-234-2345 (health professionals only).

PRINT CLEAR FORM