BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

CHRONIC HEPATITIS B

HLTH 5372 Rev. 2016/10/20

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, NON-CIRRHOSIS (if space needed for comments, see page 2)

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

3.1 LAMIVUDINE – INITIAL COVERAGE: INDEFINITE (complete Section A or B as appropriate)

	PROVIDE DATES AND VALUES OR ATTACH LAB REPORT	
SECTION A – COMPLETE 1 AND (2 OR 3)	DATE	VALUE and (ULN if applicable)
1. ☐ **HBeAg Positive**		
AND 2. ☐ HBV DNA ≥ 100,000 copies/ml		
AND ☐ ALT Level ≥ 1.3 x ULN (Upper Limit of Normal)		
OR 3. ☐ HBV DNA < 100,000 copies/ml		
AND ☐ ALT level ≥ 2 x ULN		

SECTION B	DATE	VALUE and (ULN if applicable)
☐ **HBeAg Negative**		
AND ☐ HBV DNA > 10,000 copies/ml		
AND ☐ ALT Level ≥ 1.3 x ULN		

3.2 INTERFERON ALFA – INITIAL COVERAGE: 24 WEEKS (*Patients who are HBV-DNA positive and anti-HB positive (precore mutant pattern) do not respond well to interferon)*

	DATE	VALUE and (ULN if applicable)
☐ **HBeAg Positive**		
AND ☐ HBV DNA detectable		
AND ☐ ALT Level > 2 x ULN		

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 (if space needed for comments, see below)

☐ TENOFOVIR 300 MG DAILY INITIAL COVERAGE: INDEFINITE, **OR** ☐ ADEFOVIR 10 MG DAILY INITIAL COVERAGE: INDEFINITE
(Reduced dose recommended for renal insufficiency)

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

SECTION 5 – INITIAL COVERAGE, CIRRHOSIS (if space needed for comments, see below)

☐ Histologic or radiologic evidence of cirrhosis or other evidence of portal hypertension **AND** ☐ Supporting evidence attached

Select medication and complete the appropriate fields		**PROVIDE DATES AND VALUES OR ATTACH LAB REPORT** DATE	VALUE and (ULN if applicable)
☐ **LAMIVUDINE 100 mg daily coverage – indefinite**	☐ HBV DNA detectable		
☐ **TENOFOVIR 300 mg daily coverage – indefinite** ☐ **ENTECAVIR 0.5 mg daily coverage – indefinite**	☐ HBV DNA ≥ 1M copies		
	OR ☐ HBV DNA > 10,000 < 1M copies		
	AND ☐ ALT ≥ 3 x ULN		

SECTION 6 – RENEWAL COVERAGE

		PROVIDE DATES AND VALUES OR ATTACH LAB REPORT DATE	VALUE
One renewal only by reapplication ☐ **Interferon-alfa up to 24 weeks**	☐ HBV DNA undetectable within the last 3 months		

SECTION 7 – ADDITIONAL COMMENTS (IF APPLICABLE)

SECTION 8 – 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)

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.

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

PRINT CLEAR FORM