BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

RITUXIMAB FOR RHEUMATOID ARTHRITIS INITIAL / RENEWAL

HLTH 5373 Rev. 2017/01/11

☐ **INITIAL**
Complete sections 1-4, 6.
Also complete section 8 if applicable.

☐ **RENEWAL**
Complete sections 1-5.

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 RHEUMATOLOGIST'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 – INITIAL OR RENEWAL COVERAGE

☐ **RITUXIMAB – INITIAL COVERAGE, TWO COURSES, IN COMBINATION WITH CONCURRENT DMARD**
Each course is 1000 mg at 0 & 2 weeks, mininum 24 weeks between courses. A minimum ACR20 response is required after the initial course for retreatment.

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate, in patients who have failed to respond to an adequate trial of at least one anti-TNF agent OR have contraindication(s) to anti-TNF agents. Rituximab should not be used concomitantly with anti-TNF agents.

☐ **RITUXIMAB – RENEWAL, TWO COURSES**
Each course is 1000 mg at 0 & 2 weeks, minimum 24 weeks between courses. A minimum ACR20 response compared to pre-rituximab status is required for treatment.
If not anticipating use of 1000 mg at 0 and 2 week dosing give details of planned alternate dosing regimen:

DATE OF LAST RITUXIMAB INFUSION (YYYY / MM / DD)

MONTH & YEAR PATIENT BEGAN RITUXIMAB THERAPY (MM / YYYY)

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

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

PATIENT NAME	PHN

SECTION 4 – CURRENT CLINICAL ASSESSMENT (REQUIRED FOR ALL APPLICATIONS)

68 JOINT COUNT: NO. OF SWOLLEN JOINTS	NO. OF TENDER JOINTS	ESR OR CRP	DURATION OF MORNING STIFFNESS	DOSE OF PREDNISONE

PHYSICIAN OVERALL ASSESSMENT OF ***INFLAMMATION*** (ON A SCALE OF 0 - 10) 0 = REMISSION, 10 = SEVERE ACTIVE DISEASE	☐ HEALTH ASSESSMENT QUESTIONNAIRE (HAQ) COMPLETED BY PATIENT AND ATTACHED

CONCURRENT DMARD THERAPY:	DRUG	DOSE ROUTE	FREQUENCY
OR	DRUG	DOSE ROUTE	FREQUENCY
SPECIFY CONTRAINDICATIONS TO USE IN SECTION 7.	DRUG	DOSE ROUTE	FREQUENCY

SECTION 5 – ASSESSMENT 4 MONTHS POST MOST RECENT RITUXIMAB COURSE (REQUIRED FOR RENEWALS)

☐ AFTER MOST RECENT RITUXIMAB COURSE, AT LEAST 20% IMPROVEMENT (ACR20) WAS ACHIEVED COMPARED TO STATUS JUST PRIOR TO INITIAL RITUXIMAB THERAPY.

ANTICIPATED RETREATMENT DATE (APPROXIMATE IF EXACT DATE UNKNOWN): _____

SECTION 6 – PRIOR BIOLOGICS AND REASON FOR DISCONTINUATION OR CONTRAINDICATIONS TO OTHER BIOLOGICS

NAME, DOSE & FREQUENCY	DURATION, PLEASE SPECIFY DATES	FAILURE		SIDE EFFECT(S) OR CONTRAINDICATION(S) - PLEASE SPECIFY
		TYPE I*	TYPE II**	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

Report all adverse events to the post-market surveillance program, Canada Vigilance, toll-free 1-866-234-2345 (health professionals only).

* Never achieving a 20% improvement

** At least 20% improvement in first 12 weeks of a TNF inhibitor (24 weeks for abatacept and rituximab) but loss of benefit

SECTION 7 – ADDITIONAL COMMENTS

ADDITIONAL COMMENTS REGARDING PATIENT'S CURRENT MEDICAL STATUS AND/OR CONTRAINDICATIONS TO CONCURRENT DMARD THERAPY

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.

_____

Prescribing 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.

PATIENT NAME	PHN

SECTION 8 – SUPPLEMENTAL PAGE - CRITERIA FOR INITIAL COVERAGE

Complete if biologic coverage has not previously been approved by PharmaCare for this patient; this page does not need to be completed or submitted if PharmaCare has previously approved coverage of a biologic for the treatment of rheumatoid arthritis for this patient.

YEAR OF DIAGNOSIS OF RHEUMATOID ARTHRITIS (YYYY)

DMARD UTILIZATION	INDICATE AND SPECIFY ALL THAT APPLY TO THE PATIENT'S DMARD UTILIZATION		
	Lack of Effect	**Intolerance/Side Effect(s)**	**Contraindications**
☐ **methotrexate** parenteral 25 mg (15 mg for over 65 years), minimum 8 weeks required			
PLUS two or more of the following – required			
☐ a) **leflunomide** 20 mg daily for 10 weeks			
☐ b) **gold** weekly injections for 20 weeks			
☐ c) **sulfasalazine** ≥ 2 gm daily for 3 months			
☐ d) **azathioprine** 2-3 mg/kg/day for 3 months			
☐ e) **other** – specify drug, dose, duration			
☐ f) **other** – specify drug, dose, duration			
PLUS at least one DMARD combination (NOTE: antimalarial in combination with one other DMARD is not acceptable)			
☐ a) methotrexate with cyclosporine minimum 4 months			
☐ b) methotrexate with hydroxychloroquine and sulfasalazine (O'Dell protocol), minimum 4 months			
☐ c) methotrexate with gold, minimum 20 week trial			
☐ d) methotrexate with leflunomide, minimum 10 week trial			
☐ e) other – specify drugs, duration			

PRINT RESET