



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.

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 - INITIAL OR RENEWAL COVERAGE

RITUXIMAB: 9901-0156

Form for Section 3 containing checkboxes for Rituximab - Initial Coverage and Rituximab - Renewal, with detailed instructions and a date of last infusion field.

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

Table for Pharmacist Use Only with columns for Status, Effective Date, and Duration of Approval.

# RITUXIMAB FOR RHEUMATOID ARTHRITIS

PATIENT NAME	PHN
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## 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 <b><i>INFLAMMATION</i></b> (ON A SCALE OF 0 - 10) 0 = REMISSION, 10 = SEVERE ACTIVE DISEASE				<input type="checkbox"/> HEALTH ASSESSMENT QUESTIONNAIRE (HAQ) COMPLETED BY PATIENT AND ATTACHED			
<b>CONCURRENT DMARD THERAPY:</b>	DRUG		DOSE ROUTE		FREQUENCY		
<b>OR</b>	DRUG		DOSE ROUTE		FREQUENCY		
<b>SPECIFY CONTRAINDICATIONS TO USE IN SECTION 7.</b>	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 – MOST RECENT TARGETED DMARD AND REASON FOR DISCONTINUATION

**Additional information regarding prior targeted DMARD trial(s) will be requested if required.**

NAME, DOSE & FREQUENCY	APPROX. DURATION OF USE	FAILURE		SIDE EFFECT(S) OR OTHER DETAILS - SPECIFY
		TYPE I*	TYPE II**	
		<input type="checkbox"/>	<input type="checkbox"/>	

\* 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

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

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