



ADALIMUMAB / ETANERCEPT / INFLIXIMAB / RISANKIZUMAB / SECUKINUMAB / USTEKINUMAB / IXEKIZUMAB FOR THE TREATMENT OF MODERATE TO SEVERE PLAQUE PSORIASIS

INITIAL Complete sections 1 - 5

SWITCH Complete sections 1 - 4, and 6

RENEWAL Complete sections 1 - 4, and 7

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 DERMATOLOGIST INFORMATION

Name and Mailing Address
College ID (use ONLY College ID number)
Phone Number (include area code)
Prescriber's Fax Number
CRITICAL FOR A TIMELY RESPONSE

SECTION 2 - PATIENT INFORMATION

Patient (Family) Name
Patient (Given) Name(s)
Date of Birth (YYYY / MM / DD)
Date of Application (YYYY / MM / DD)
Personal Health Number (PHN)
CRITICAL FOR PROCESSING

SECTION 3 - MEDICATION REQUESTED

PATIENT WEIGHT (KG) (REQUIRED FOR ALL MEDICATIONS):
ADALIMUMAB INITIAL/RENEWAL
ETANERCEPT INITIAL/RENEWAL
SECUKINUMAB INITIAL/RENEWAL
RISANKIZUMAB INITIAL/RENEWAL
INFLIXIMAB: INFLECTRA®/RENFLEXIS®
INFLIXIMAB INITIAL/RENEWAL
USTEKINUMAB INITIAL/RENEWAL
IXEKIZUMAB INITIAL/RENEWAL

SECTION 4 - PRESCRIBER SIGNATURE

Please complete additional criteria on page 2

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.

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.

PHARMACARE USE ONLY

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

PATIENT NAME	PERSONAL HEALTH NUMBER (PHN)	DATE (YYYY / MM / DD)
--------------	------------------------------	-----------------------

SECTION 5 – INITIAL COVERAGE

Due to the documented potential serious adverse events, more cost-effective alternatives available, and the high per patient costs, these medications are Limited Coverage benefits subject to requirements of the Special Authority process.

ALL THE FOLLOWING CRITERIA HAVE TO BE MET:

Patient is 18 years of age or older
 Patient has a body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genital region
 Patient failed to respond, is intolerant, or is unable to access UV phototherapy
 Patient has a baseline pre-biologic PASI of >12.
 Specify current PASI score (*completed within past 90 days*): _____ Date PASI conducted: _____

Patient has failed to respond, or experienced a specific intolerance, or has a specific contraindication to both of the following medications:

	Lack of Effect	Intolerance (specify below)	Contraindication(specify below)
<input type="checkbox"/> methotrexate oral/parenteral 20 mg weekly (15 mg for ages > 65) for 3 months For intolerance or contraindication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> significant liver disease (abnormal liver biopsy, chronic hepatitis, or liver enzymes 3X ULN) Provide details below and lab reports/consults to support. provide details: _____			
<input type="checkbox"/> other (specify): _____			
	Lack of Effect	Intolerance (specify below)	Contraindication(specify below)
<input type="checkbox"/> cyclosporine 4mg/Kg daily for 3 months For intolerance or contraindication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> significant kidney disease (serum creatinine elevation >30% over baseline on 2 or more occasions, known kidney disease) Provide details below and lab reports/consults to support. provide details: _____			
<input type="checkbox"/> persistent hypertension uncontrolled by optimal antihypertensive therapy - provide current blood pressure on cyclosporine: _____ specify current antihypertensive therapy: _____			
<input type="checkbox"/> other (specify): _____			

SECTION 6 – SWITCHING TO ANOTHER BIOLOGIC

Name and dose of biologic being discontinued: _____

Date biologic was discontinued: _____ Length of biologic trial: _____

Reason for discontinuation of biologic

Patient failed to achieve a PASI \geq 75 from baseline biologic naive PASI score after initial trial of previous biologic
 Patient failed to maintain a PASI \geq 50 from baseline biologic naive PASI score while on maintenance therapy of previous biologic
 Other (please specify): _____

Current PASI score (*completed within past 90 days*): _____ Date PASI conducted: _____

SECTION 7 – RENEWAL OF COVERAGE

Pre-Biologic PASI score: _____ Current PASI score (<i>completed within past 90 days</i>): _____ Date PASI conducted*: _____ *Short term coverage may be provided to allow for completion of PASI. Provide additional details in area provided. First Renewal after the initial 12 to 16 week trial of biologic <input type="checkbox"/> Patient has obtained a PASI \geq 75 from the baseline biologic naive PASI score Subsequent Renewals for Maintenance Therapy <input type="checkbox"/> Patient has maintained a PASI \geq 50 from the baseline biologic naive PASI score	Additional Information:
---	-------------------------