BRITISH COLUMBIA | Ministry of Health

*SPECIAL AUTHORITY REQUEST*

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

HLTH 5380 Rev. 2018/08/13

☐ **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 ☐ 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 – MEDICATION REQUESTED

PATIENT WEIGHT (KG)
**(REQUIRED FOR ALL MEDICATIONS):**

| | |
|---|---|
| ☐ **ADALIMUMAB INITIAL**<br>INITIAL DOSE 80 MG, THEN 40 MG WEEK 1, THEN 40 MG EVERY 2 WEEKS FOR 16 WEEKS | ☐ **ADALIMUMAB RENEWAL**<br>40 MG EVERY 2 WEEKS FOR 1 YEAR |
| ☐ **ETANERCEPT INITIAL**<br>50 MG TWICE WEEKLY FOR 12 WEEKS | ☐ **ETANERCEPT RENEWAL**<br>50 MG WEEKLY OR TWICE WEEKLY FOR 1 YEAR |
| ☐ **SECUKINUMAB INITIAL**<br>300 MG AT WEEK 0, 1, 2, 3 AND 4, THEN 300 MG MONTHLY FOR 12 WEEKS | ☐ **SECUKINUMAB RENEWAL**<br>300 MG MONTHLY FOR ONE YEAR |

| | |
|---|---|
| ☐ **INFLIXIMAB (INFLECTRA™) INITIAL**<br>☐ **INFLIXIMAB (RENFLEXIS™) INITIAL**<br>5 MG/KG AT 0, 2 AND 6 WEEKS | ☐ **INFLIXIMAB RENEWAL**<br>5 MG/KG EVERY 8 WEEKS FOR 1 YEAR |
| ☐ **USTEKINUMAB INITIAL**<br>< 100 KG: 45 MG AT WEEK 0, 4 AND 16<br>> 100 KG: 90 MG AT WEEK 0, 4 AND 16 | ☐ **USTEKINUMAB RENEWAL**<br>< 100 KG: 45 MG EVERY 12 WEEKS<br>> 100 KG: 90 MG EVERY 12 WEEKS FOR 1 YEAR |
| ☐ **IXEKIZUMAB INITIAL**<br>160 MG AT WK 0, THEN 80 MG AT WKS 2, 4, 6, 8, 10, AND 12 WKS | ☐ **IXEKIZUMAB RENEWAL**<br>80 MG EVERY 4 WEEKS FOR 1 YEAR |

**Please complete additional criteria on page 2 →**

## SECTION 4 – PRESCRIBER 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.***

## PHARMACARE USE ONLY

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

PRINT RESET

| 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) |
|---|---|---|---|
| ☐ **methotrexate** | ☐ | ☐ | ☐ |

oral/parenteral 20 mg weekly (15 mg for ages > 65) for 3 months

***For intolerance or contraindication***

- ☐ significant liver disease (abnormal liver biopsy, chronic hepatitis, or liver enzymes 3X ULN) **Provide details below and lab reports/consults to support.**

  **provide details:** _____
- ☐ other (specify): _____

| | Lack of Effect | Intolerance (specify below) | Contraindication(specify below) |
|---|---|---|---|
| ☐ **cyclosporine** | ☐ | ☐ | ☐ |

4mg/Kg daily for 3 months

***For intolerance or contraindication***

- ☐ 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:** _____
- ☐ persistent hypertension uncontrolled by optimal antihypertensive therapy - **provide current blood pressure on cyclosporine:** _____

  **specify current antihypertensive therapy:** _____
- ☐ 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 ≥ 75 from baseline biologic naive PASI score after initial trial of previous biologic
- ☐ Patient failed to maintain a PASI ≥ 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 *(completed within past 90 days):* _____

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

- ☐ Patient has obtained a PASI ≥ 75 from the baseline biologic naive PASI score

Subsequent Renewals for Maintenance Therapy

- ☐ Patient has maintained a PASI ≥ 50 from the baseline biologic naive PASI score

Additional Information: