BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

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

HLTH 5380 Rev. 2022/12/05

◯ **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 privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

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.

If you have received this fax in error, please write MISDIRECTED across the front of the form and fax toll-free to 1-800-609-4884, then destroy the pages received in error.

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'S INFORMATION

Name and Mailing Address

College ID (use ONLY College ID number)

Phone Number (include area code)

CRITICAL FOR A TIMELY RESPONSE → Dermatologist'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 **(required for all medications)**

◯ **ADALIMUMAB**
- ◯ **Initial**: Initial dose 80 mg, then 40 mg week 1, then 40 mg every 2 weeks for 16 weeks
- **OR** ◯ **Renewal**: 40 mg every 2 weeks for 1 year

◯ **ABRILADA®** ◯ **AMGEVITA®** ◯ **HADLIMA®** ◯ **HULIO®**
◯ **HYRIMOZ®** ◯ **IDACIO®** ◯ **SIMLANDI™** ◯ **YUFLYMA®**

◯ **BIMEKIZUMAB**
- ◯ **Initial**: 320 mg every 4 weeks for 16 weeks
- **OR** ◯ **Renewal**: 320 mg every 8 weeks for 1 year

◯ **ETANERCEPT**
- ◯ **Initial**: 50 mg twice weekly for 12 weeks
- **OR** ◯ **Renewal**: 50 mg weekly to twice weekly for 1 year

◯ **BRENZYS®** ◯ **ERELZI®**

◯ **INFLIXIMAB**
- ◯ **Initial**: 5 mg/kg at 0, 2 and 6 weeks
- **OR** ◯ **Renewal**: 5 mg/kg every 8 weeks for 1 year

◯ **AVSOLA®** ◯ **INFLECTRA®** ◯ **RENFLEXIS®**

◯ **IXEKIZUMAB**
- ◯ **Initial**: 160 mg at week 0, then 80 mg at weeks 2, 4, 6, 8, 10 and 12 weeks
- **OR** ◯ **Renewal**: 80 mg every 4 weeks for 1 year

◯ **RISANKIZUMAB**
- ◯ **Initial**: 150 mg at week 0, 4 and 16
- **OR** ◯ **Renewal**: 150 mg every 12 weeks for 1 year

◯ **SECUKINUMAB**
- ◯ **Initial**: 300 mg at week 0, 1, 2, 3 and 4, then 300 mg monthly for 12 weeks
- **OR** ◯ **Renewal**: 300 mg monthly for 1 year

◯ **USTEKINUMAB**
- ◯ **Initial**: < 100 kg: 45 mg at week 0, 4 and 16
  > 100 kg: 90 mg at week 0, 4 and 16
- **OR** ◯ **Renewal**: <100 kg: 45 mg every 12 weeks
  >100 kg: 90 mg every 12 weeks for 1 year

SECTION 4 – PRESCRIBER SIGNATURE

Please complete additional criteria on page 2 →

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* 22(1) and *Freedom of Information and Protection of Privacy Act* 26 (a),(c),(e). The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection 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	DURATION OF THERAPY / TERMINATION DATE

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 (provide supporting details)
- ☐ 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

- ☐ **Patient requires restarting after remission**
  Provide current PASI and date conducted in Section 7 above

Additional Information:

Save Print Clear Form