BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

NATALIZUMAB (TYSABRI) FOR MULTIPLE SCLEROSIS

HLTH 5385 Rev. 2022/01/18

◯ **INITIAL**
Complete sections 1, 2, & 3

◯ **RENEWAL**
Complete sections 1, 2, & 4

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 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 device 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 – NEUROLOGIST'S INFORMATION

Neurologist's Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Neurologist'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 COVERAGE CRITERIA FOR NATALIZUMAB (TYSABRI), 300 mg IV every 4 weeks

NATALIZUMAB: 9901-0188

☐ As second-line monotherapy for the treatment of relapsing-remitting multiple sclerosis (RRMS) which is diagnosed according to the current clinical criteria and magnetic resonance imaging (MRI) evidence.

☐ Prescribed by a neurologist from a designated multiple sclerosis clinic.

Most recent EDSS score _____ , date _____ .

PLUS for patients meeting ALL of the following:

A. ☐ Significant increase in T2 lesion load compared to a previous MRI scan or at least one gadolinium-enhancing lesion, AND

B. ☐ Failure to respond to full and adequate courses of treatment with one other disease modifying therapy (interferon beta-1a, interferon beta-1b, glatiramer acetate, dimethyl fumarate, teriflunomide), OR contraindication or intolerance to two of these therapies.

	NAME OF PREVIOUS DISEASE MODIFYING AGENT	DOSE	DURATION OF TRIAL (MONTHS)	DETAILS OF OUTCOME (FAILURE, CONTRAINDICATION, INTOLERANCE, OTHER)
1				◯ Failure ◯ Contraindication ◯ Intolerance ◯ Other Specify:
2				◯ Failure ◯ Contraindication ◯ Intolerance ◯ Other Specify:

Please complete additional information on page 2 >>

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE	DURATION OF THERAPY / TERMINATION DATE

NATALIZUMAB MONOTHERAPY INITIAL/RENEWAL REQUEST FOR MULTIPLE SCLEROSIS

PATIENT NAME	PHN	DATE (YYYY / MM / DD)

SECTION 4 – RENEWAL COVERAGE CRITERIA FOR NATALIZUMAB (TYSABRI), 300 mg IV every 4 weeks monotherapy

☐ As monotherapy for the treatment of relapsing-remitting multiple sclerosis.

☐ Prescribed by a neurologist from a designated multiple sclerosis clinic.

☐ The patient has had continued therapeutic benefit since the initiation of disease modifying therapy, outweighing any potential risks.

Were neutralizing antibodies present after 6 months? ◯ Yes ◯ No

If yes, were neutralizing antibodies present on repeat testing after an additional 3 months? ◯ Yes ◯ No

PLUS evidence of continued benefit (improvement or stabilization) as shown by at least ONE of the following:
(for patients 60 years of age and older, please complete section 4A, 4B and 4E below in full)

A. ☐ Reduction in relapse rate (decrease from _____ relapses per year to _____ relapses per year).

B. ☐ Improvement or stability of EDSS score. Most recent EDSS score _____ date _____

Previous EDSS score _____ date _____

C. ☐ MRI scan: Reduction or stability in lesion load.

D. ☐ MRI scan: Reduction in gadolinium enhancing lesions.

E. ☐ Overall clinical impression of benefit (provide details):

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.

_____
Neurologist'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.

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