BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

APIXABAN / DABIGATRAN / RIVAROXABAN FOR ATRIAL FIBRILLATION

HLTH 5391 Rev. 2018/10/17

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 – PRESCRIBER 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 – BACKGROUND DIAGNOSTIC INFORMATION

☐ Patient has a diagnosis of non-valvular atrial fibrillation (patient does **NOT** have hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis, or prosthetic heart valves), **AND** at least one CHADS2 related risk factor identified below. For patients 75 years of age or older renal function has been adequate (as defined below) as well as stable for at least 3 months.

☐ **C**ongestive heart failure ☐ **H**ypertension ☐ **A**ge of at least 75 years ☐ **D**iabetes Mellitus ☐ Prior **S**troke/transient ischemic event

SECTION 4 – MEDICATION AND DOSE SELECTION

☐ APIXABAN: 9901-0233

(CrCL or eGFR of at least 25 mL/min)

☐ 5 mg twice daily

☐ 2.5 mg twice daily (recommended if patient has at least two of: Age ≥ 80, body weight ≤ 60 kg, or serum creatinine ≥ 133 mmol/L).

☐ DABIGATRAN: 9901-0192

☐ 150 mg twice daily, patient has CrCL or eGFR of at least 50 mL/min

☐ 110 mg twice daily, patient has CrCL or eGFR of at least 30-49 mL/min

☐ RIVAROXABAN: 9901-0199

☐ 20 mg once daily, patient has CrCL or eGFR of at least 50 mL/min

☐ 15 mg once daily, patient has CrCL or eGFR of at least 30-49 mL/min

SECTION 5 – RESULTS OF A PAST TRIAL WITH WARFARIN OR CONTRAINDICATIONS TO WARFARIN

5A INADEQUATE ANTICOAGULATION AFTER A MINIMUM 2 MONTH WARFARIN TRIAL

☐ After **AT LEAST** a 2 month warfarin trial INR testing results are outside the desired range for at least 35% of the tests, **OR**

5B ANTICOAGULATION WITH WARFARIN IS CONTRAINDICATED OR NOT POSSIBLE DUE TO:

☐ Inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home)

☐ Other reasons as applicable
(please give as much information as possible for consideration):

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 CLEAR FORM