BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST
DABIGATRAN FOR ATRIAL FIBRILLATION

HLTH 5391 Rev. 2023/12/05

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 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 – PRESCRIBER INFORMATION

Name and Mailing Address	
College ID (use ONLY College ID 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 AND DOSE SELECTION

◯ **DABIGATRAN 110, 150mg: 9901-0192**

SECTION 4 – CRITERIA FOR INDEFINITE COVERAGE *(please note apixaban and rivaroxaban are PharmaCare regular benefits)*

4A ☐ 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

4B WARFARIN IS NOT SUITABLE FOR THIS PATIENT DUE TO ONE OF THE FOLLOWING:

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

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

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

Note: Recommended dabigatran dosing based on creatinine clearance or estimated glomerular filtration rate: 30-49 mL/min for 110 mg twice daily dosing or ≥ 50 mL/min for 150 mg twice daily dosing.

SECTION 5 – PRESCRIBER SIGNATURE

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 (YYYY / MM / DD)	DURATION OF APPROVAL

Save Print Clear Form