BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

FINGOLIMOD FOR MULTIPLE SCLEROSIS

HLTH 5394 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 FOR FINGOLIMOD, 0.5 mg once daily: 15 MONTHS

FINGOLIMOD: 9901-0228

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

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

☐ EDSS score 5.5 or less. Most recent EDSS score: _____ exam date: _____

☐ Patient has not experienced a heart attack or stroke in the last six months and does not have a history of sick sinus syndrome, atrioventricular block, significant QT prolongation, bradycardia, ischemic heart disease or congestive heart failure.

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. ☐ One or more disabling relapses in the previous one (1) year, AND

C. ☐ Failure to respond to full and adequate courses of treatment with at least one interferon (interferon beta-1a or interferon beta-1b) OR glatiramer acetate OR dimethyl fumarate OR teriflunomide OR rituximab

OR

☐ Has documented intolerances or contraindications to at least two (2) of the following: interferon (interferon beta-1a or interferon beta-1b), glatiramer acetate, dimethyl fumarate, teriflunomide OR rituximab

	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 (YYYY / MM / DD)	DURATION OF APPROVAL

FINGOLIMOD FOR MULTIPLE SCLEROSIS

Patient (Family) Name	Patient (Given) Name(s)	Personal Health Number (PHN)

SECTION 4 – RENEWAL COVERAGE FOR FINGOLIMOD, 0.5 mg once daily monotherapy: TWO YEARS

☐ As second-line monotherapy for the treatment of relapsing-remitting multiple sclerosis.
☐ Prescribed by a neurologist from a designated multiple sclerosis clinic.

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

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 4 A and D below in full)

A. ☐ Reduction in relapse rate (decrease from _____ relapses per year to _____ relapses per year).
B. ☐ MRI scan: Reduction or stability in lesion load.
C. ☐ MRI scan: Reduction in gadolinium enhancing lesions.
D. ☐ Overall clincial impression of benefit.

Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).

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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