BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

DUPILUMAB (6 - 11 YEARS OLD)

FOR THE TREATMENT OF SEVERE EOSINOPHILIC ASTHMA

HLTH 5459 2023/10/11

◯ **INITIAL - Complete sections 1 - 4** ◯ **RENEWAL - Complete sections 1 - 3, and 5**

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 – PRESCRIBING RESPIROLOGIST'S/ALLERGIST'S INFORMATION

Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Respirologist's/Allergist'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

DUPILUMAB (6 - 11 YEARS OLD) **9901-0432**

15 to < 30 kg: 100 mg every 2 weeks or 300 mg every 4 weeks;
30 to <60 kg: 200 mg every 2 weeks or 300 mg every 4 weeks;
60 kg or more: 200 mg every 2 weeks

Dupilumab should not be used in combination with other biologics to treat asthma (PharmaCare will only cover ONE biologic for asthma at a time).

SECTION 4 – CRITERIA FOR INITIAL COVERAGE: 1 YEAR

PharmaCare coverage is considered for the add-on maintenance treatment of severe eosinophilic asthma in patients 6 to 11 years old when requested by a respirologist/allergist with expertise in treating asthma.

Approval subject to ALL of the criteria below being met (mark boxes and complete blanks as applicable):

A. ☐ Patient has severe eosinophilic asthma with blood eosinophil count ≥ 150 cells/mcL and **lab reports are attached**.

AND

☐ **In the past 12 months**, due to an asthma exacerbation, patient has experienced a minimum of 1 hospital or emergency room visit **OR** 2 or more courses of systemic corticosteroids. Please complete the following:

_____ **Number of courses of systemic glucocorticoids administered** due to an asthma exacerbation in the past 12 months.

_____ **Number of emergency department visits** due to an asthma exacerbation in the past 12 months.

_____ **Number of hospitalizations** due to an asthma exacerbation in the past 12 months.

B. ☐ Eosinophilic asthma symptoms are currently inadequately controlled with high-dose inhaled corticosteroids, of ≥ 400 mcg of fluticasone propionate or equivalent daily **for a minimum of 6 months**, combined with one or more additional optimally dosed asthma treatments (combination therapy for a minimum of 3 months):

MEDICATION TRIALED	DOSE AND FREQUENCY	DURATION OF TRIAL	RESPONSE
☐ Inhaled corticosteroid **Drug name:**			
☐ Long-acting beta-agonist (LABA) **Drug name:**			
☐ Other **Drug name:**			

C. ☐ Please complete the **Asthma Control Questionnaire-5 (ACQ-5)** mean score **within 90 days prior** to treatment with dupilumab.

	DATE (YYYY/MM/DD)	SCORE
Prior to dupilumab treatment (within 90 days)		

Please complete additional information on page 2 >>

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

SECTION 5 – CRITERIA FOR RENEWAL: 1 YEAR

A. Prescriber authorizing this request is a respirologist/allergist

B. ☐ Asthma Control Questionnaire-5 (ACQ-5) must demonstrate minimal clinically important difference of improvement for first renewal defined as a decrease of ≥ 0.5 points of the mean score compared to pre-treatment mean score.
Please note: The difference in score achieved the first year must be maintained for continued renewal

Please complete a. and b. for first renewal and ALL rows for subsequent renewals.

		DATE (YYYY/MM/DD)	SCORE	SCORE DIFFERENCE
a.	Pre-dupilumab (within 90 days prior to treatment)		**Pre-treatment score:**	
b.	**First renewal at 12 months:** Post-dupilumab (between 9-12 months from treatment initiation)		**First renewal score:**	**(Pre-treatment score) - (First renewal score)**
c.	**Subsequent renewal:** Current (within past 90 days)		**Current score:**	**(Pre-treatment score) - (Current score)**

C. ☐ Patient's number of clinically significant exacerbations have stabilized or improved versus baseline. **Provide:**

_____ **Number of courses of systemic glucocorticoids administered** due to an asthma exacerbation in the past 12 months.

_____ **Number of emergency department visits** due to an asthma exacerbation in the past 12 months.

_____ **Number of hospitalizations** due to an asthma exacerbation in the past 12 months.

SECTION 6 – ADDITIONAL COMMENTS

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.

_____
Respirologist's/Allergist'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

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