BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

NINTEDANIB AND PIRFENIDONE FOR IDIOPATHIC PULMONARY FIBROSIS

HLTH 5468 Rev. 2018/10/17

☐ **INITIAL (complete section 1-3, 5 if applicable)** ☐ **RENEWAL (complete section 1-2, 4, 5 if applicable)**

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 – PRESCRIBING RESPIROLOGIST'S INFORMATION

NAME AND MAILING ADDRESS ☐ MAIL CONFIRMATION

☐ COLLEGE ID **OR** ☐ MSP NUMBER

PHONE NUMBER (INCLUDE AREA CODE)

CRITICAL FOR A TIMELY RESPONSE →

RESPIROLOGIST'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 DETAIL INFORMATION

3A: MEDICATION REQUESTED (nintedanib + pirfenidone combination not eligible for coverage)

☐ **NINTEDANIB: 9901-0295**
(100 mg, 150 mg capsules)

150 mg twice daily, or 100 mg twice daily if dose reduction required.

OR

☐ **PIRFENIDONE: 9901-0294**
(267 mg capsules and tablets, 801 mg tablets)

Days 1 to 7: a dose of 267 mg administered, three times a day.
Days 8 to 14: a dose of 534 mg administered, three times a day.
Day 15 onward: up to a dose of 801mg administered, three times a day.

☐ **3B: INITIAL APPROVAL - 7 MONTHS**

For the treatment of adult patients who have a diagosis of mild to moderate idiopathic pulmonary fibrosis (IPF) confirmed by a respirologist and a high-resolution CT scan within the previoius 24 months. For patients diagnosed with IPF, mild to moderate disease is defined as FVC greater than or equal to 50% of predicted. Initial approval is for a total of seven months, to allow for repeat PFT's at 6 months, and a retest at seven months if necessary.

☐ Current % of predicted FVC value: _____ (and attach copy of PFT report done within the last three months)

☐ Patient is under the care of a respirologist with experience treating IPF and the diagnosis has been confirmed by a respirologist within the last 24 months.

☐ Copy of high resolution CT scan report/summary indicating findings of IPF (from within the last 24 months) is attached. If HRCT report is inconclusive (e.g. suggests probable or possible IPF) please submit additional supporting information such as the results from a Multi-Disciplinary Discussion of case, and/or other details of clinical history that support IPF diagnosis.

☐ All other causes of restrictive lung disease listed below have been excluded:

Occupational Exposure:	☐ Yes	☐ No (if diagnosis is still considered to be IPF, please provide additional details in Section 5)
Antigen Exposure:	☐ Yes	☐ No (if diagnosis is still considered to be IPF, please provide additional details in Section 5)
Connective Tissue Disease:	☐ Yes	☐ No (if diagnosis is still considered to be IPF, please provide additional details in Section 5)
Drug Exposure:	☐ Yes	☐ No (if diagnosis is still considered to be IPF, please provide additional details in Section 5)

Please complete additional information on page 2 >>

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

HLTH 5468

NINTEDANIB AND PIRFENIDONE FOR IDIOPATHIC PULMONARY FIBROSIS

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

SECTION 4 – RENEWALS

4A: MEDICATION REQUESTED (nintedanib + pirfenidone combination not eligible for coverage)

☐ **Nintedanib** (100 mg, 150 mg capsules) **OR** ☐ **Pirfenidone** (267 mg capsules and tablets, 801 mg tablets)

Dosing Regimen: _____

☐ **4B: FIRST RENEWAL - 7 MONTHS**

Patients must NOT demonstrate progression of disease, defined as an absolute decline in percent predicted of FVC ≥10% from initiation of therapy until this renewal. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory PFT conducted 4 weeks later.

☐ Current % of predicted FVC value: _____ (and attach copy of PFT report done within the last three months)

☐ **4C: SECOND AND SUBSEQUENT RENEWALS - 1 YEAR**

Patients must NOT demonstrate progression of disease, defined as an absolute decline in percent predicted of FVC ≥10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory PFT conducted 4 weeks later.

☐ Current % of predicted FVC value: _____ (and attach copy of PFT report done within the last three months)

SECTION 5 – ADDITIONAL INFORMATION (ADDITIONAL NOTES IF REQUIRED)

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.

_____

Respirologist's Signature (Mandatory)

PRINT CLEAR FORM