BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

MEDICATION COVERAGE FOR ATTENTION DEFICIT AND HYPERACTIVITY DISORDER (ADHD)

HLTH 5472 Rev. 2020/05/17

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

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 – DIAGNOSIS (REQUIRED FOR ALL DRUGS)

☐ **Patient is 6 years of age or older, and has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) with hyperactivity, impulsivity, or inattention that interferes with functioning.**

SECTION 4 – REQUESTED MEDICATION (COMPLETE EITHER A OR B)

◯ A. LONG-ACTING STIMULANT: 9901-0092

Mixed-amphetamine salts ER
Lisdexamfetamine
Methylphenidate ER (Concerta and its generics)

Criteria: ***Unsatisfactory trial of or intolerance to immediate or sustained release stimulant:*** *Unsatisfactory trial is defined as no demonstrated effectiveness for symptoms of ADHD or functional impairment secondary to ADHD after* ***a minimum 1 week trial of an adequate dose of immediate or sustained release medication.*** *Patient requires 12 hours of continuous coverage.*

◯ methylphenidate IR/SR

OR

◯ dextroamphetamine IR/SR

dose & duration of trial: _____

_____

details of unsatisfactory results or intolerance:

_____

OR

◯ B. ATOMOXETINE: 9901-0091

Criteria:

1. ***Unsatisfactory trial of or intolerance to both methylphenidate AND an amphetamine:*** *Unsatisfactory trial is defined as no demonstrated effectiveness for symptoms of or functional impairment secondary to ADHD after* ***a minimum 1 week trial of an adequate dose of both methylphenidate and an amphetamine. At least one trial must be with an extended release / long acting stimulant.***

a) **methylphenidate:** ◯ **IR / SR** ◯ **ER**

dose and duration of trial: _____

details of unsatisfactory results or intolerance: _____

_____

AND

b) **amphetamine** *(drug tried):* _____

dose and duration of trial: _____

details of unsatisfactory results or intolerance: _____

_____

OR

2. ***Patient has a contraindication to stimulants*** *(provide details):*

_____

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