BRITISH COLUMBIA | Ministry of Health

# *SPECIAL AUTHORITY REQUEST*
# EVOLOCUMAB

HLTH 5493 2022/05/16

**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 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 COVERAGE

**EVOLOCUMAB: 9901-0314**

evolocumab 420 mg (120 mg/mL) injection monthly OR 140 mg (140 mg/mL) injection every 2 weeks

## SECTION 4 – CRITERIA FOR INITIAL COVERAGE: 12 WEEKS

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

**A.** ☐ Diagnosis of "definite" or "probable" Heterozygous Familial Hypercholesterolemia (HeFH) in an adult as determined by the following:

☐ Simon Broome ☐ Dutch Lipid Network ☐ Genetic Testing

**B.** Low density lipoprotein cholesterol (LDL-C) level prior to treatment with evolocumab: _____ mmol/L

Lab Date (YYYY/MM/DD): _____

***NOTE: Prior to treatment refers to LDL-C level taken within 3 months prior to initiation of evolocumab, rather than untreated baseline LDL-C level***

**C.** ☐ LDL-C target levels ( ≤ 1.8 mmol/L for secondary prevention, or ≥ 50% reduction from untreated baseline for primary prevention) have not been met, despite meeting the following criteria: **1, plus one of 2, 3, 4, or 5:**

☐ **1.** Patient has confirmed adherence to treatment with ezetimibe for a minimum of 3 months

i. If minimum of 3 months not achieved details of intolerance: _____

**PLUS:**

☐ **2.** Atorvastatin 80mg or rosuvastatin 40mg has been tried for a minimum of 6 months with confirmed adherence

**OR** ☐ **3.** Patient is unable to tolerate at least 2 HMG-CoA Reductase Inhibitors (statins) even with dose reduction and rechallenge

i. Statin #1 tried and details of intolerance: _____

ii. Statin #2 tried and details of intolerance: _____

**OR** ☐ **4.** Patient has confirmed rhabdomyolysis

**OR** ☐ **5.** Treatment with statins is contraindicated (provide details below):

**Please complete additional information on page 2 >>**

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

## SECTION 5 – CRITERIA FOR RENEWAL OF COVERAGE: 1 YEAR

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

**A.** ☐ LDL-C is reduced by at least 40% from the LDL prior to treatment with evolocumab

***NOTE: Prior to treatment refers to LDL-C level taken within 3 months prior to initiation of evolocumab, rather than untreated baseline LDL-C level***

| LOW DENSITY LIPOPROTEIN CHOLESTEROL (LDL-C) LEVEL: | LAB DATE (YYYY/MM/DD) |
|---|---|
| **Prior to treatment with evolocumab:** _____ mmol/L | |
| **Current*:** _____ mmol/L<br>*4-8 weeks after initiation of therapy for first renewal and current (within 3 months) for subsequent renewals | |

**B.** ☐ The patient is adherent to therapy

## SECTION 6 – ADDITIONAL COMMENTS

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