BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST
TOCILIZUMAB FOR GIANT CELL ARTERITIS

HLTH 5496 2019/03/04

☐ **INITIAL (complete sections 1-5, 7)** ☐ **EXCEPTIONAL RENEWAL (complete sections 1-4, 6-7)**

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 SPECIALIST'S INFORMATION

NAME AND MAILING ADDRESS ☐ MAIL CONFIRMATION

☐ COLLEGE ID **OR** ☐ MSP NUMBER

PHONE NUMBER (INCLUDE AREA CODE)

CRITICAL FOR A TIMELY RESPONSE →

FAX NUMBER (INCLUDE AREA CODE)

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

TOCILIZUMAB: 9901-0147

☐ **TOCILIZUMAB** 162 mg sc. once every 7 days

☐ **TOCILIZUMAB** 162 mg sc. once every 14 days

☐ **OTHER** (please give regimen and details regarding need for alternate dosing as applicable): _____

SECTION 4 – CURRENT INFORMATION

Prednisone Dose:	Physician Global Assessment of ***Inflammation*** (scale of 0-10, 0=None, 10=severe active disease)	ESR or CRP	Current Weight in KG *(Required if an initial request; needed on renewal if significantly changed)*

Comments on Current Status and Treatment Plan:

List of ALL current relevant medications (i.e. for GCA, and relevant co-morbidities such as hypertension, DM, CAD)

DRUG	DOSE	FREQUENCY

Continued on page 2 >>

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE (YYYY / MM / DD)	DURATION OF APPROVAL

PATIENT NAME	PHN	DATE (YYYY / MM / DD)

SECTION 5 – INITIAL COVERAGE

5A) BACKGROUND INFORMATION

Date of Diagnosis (MM/YYYY)	CRP at Presentation or ESR at Presentation

Signs and symptoms on presentation:

- ☐ headaches
- ☐ jaw claudication
- ☐ vision changes/amaurosis
- ☐ scalp tenderness
- ☐ TIA/stroke
- ☐ elevated inflammatory markers
- ☐ other _____
- ☐ other _____
- ☐ other _____

Comments:

How was the diagnosis of GCA established?

5B) DETAILS OF TRIAL WITH PREDNISONE

Highest daily dose initially required to induce response: _____ mg/day

While tapering prednisone, at what dose did flare occur? _____ mg/day

Details of tapering course after initial response:	
List prednisone side effects as applicable:	
List co-morbidities that affect further treatment with prednisone in this patient:	

If other treatments tried, please provide details:

TREATMENT USED	STARTING DATE	DURATION OF USE	DETAILS OF TRIAL AND RESPONSE

SECTION 6 – EXCEPTIONAL RENEWAL OF COVERAGE

For consideration of exceptional renewal, provide details supporting need for ongoing treatment and attempts made to taper or discontinue tocilizumab to date. For previously approved patients, coverage was provided with the expectation that patients will taper and discontinue tocilizumab when possible.

Describe need for ongoing treatment.	
Describe attempts since prior approval to taper/ discontinue prednisone and tocilizumab; if attempts could not be made for one or both of these medications please give details.	
Anticipated duration of further tocilizumab treatment?	

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

SECTION 7 – RHEUMATOLOGIST OR OPHTHALMOLOGIST'S SIGNATURE

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.

_____

Rheumatologist or Ophthalmologist 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.

PRINT CLEAR FORM