BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST
AMIFAMPRIDINE

HLTH 5828 2023/08/14

◯ **INITIAL - Complete sections 1 - 2, and 4** ◯ **RENEWAL - Complete sections 1 - 2, and 5**

For up-to-date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority

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.

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.

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 – NEUROLOGIST INFORMATION

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

Must be requested by a neurologist with expertise in managing Lambert-Eaton myasthenic syndrome (LEMS)

Amifampridine 10mg tablets
The maximum dose of amifampridine base should not exceed 80 mg daily.
Patients between 6 and 17 years of age will be provided coverage of eligible brands of amifampridine with the Health Canada pediatric use indication. Coverage will be provided for all eligible brands of amifampridine and amifampridine phosphate for patients 18 years of age and older.

9901-0423
9901-0430

SECTION 4 – CRITERIA FOR INITIAL COVERAGE: 3 MONTHS

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

A. ☐ For the symptomatic treatment of patients with Lambert-Eaton myasthenic syndrome (LEMS) who are 6 years of age and older

B. Specify the baseline Triple Timed Up-and-Go (3TUG) test result. This result must be from within the 3 month period immediately preceding treatment initiation with amifampridine.

Triple Timed Up-and-Go (3TUG) test result	Date 3TUG calculated (YYYY/MM)
____________ seconds	

SECTION 5 – CRITERIA FOR RENEWAL: 1 YEAR

☐ Attain and maintain a minimum reduction of 30% on the current Triple Timed Up-and-Go (3TUG) test result when compared to the pre-amifampridine 3TUG test result. The current test result must be from within the 3 month period immediately preceding this request.

Triple Timed Up-and-Go (3TUG) test result	Date 3TUG calculated (YYYY/MM)
____________ seconds	

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.

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Neurologist 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

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

SECTION 6 – ADDITIONAL COMMENTS