BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

ABROCITINIB AND UPADACITINIB FOR ATOPIC DERMATITIS

HLTH 5852 Rev. 2023/11/21

◯ **INITIAL (Complete sections 1 - 4, and 7)** ◯ **SWITCH (Complete sections 1 - 3, 6, and 7)** ◯ **RENEWAL (Complete sections 1 - 3, 5, and 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 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 – PRESCRIBING SPECIALIST'S INFORMATION

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

Patient Weight
(required for all medications)

Upadacitinib or abrocitinib will not be covered for use in combination with any other immunomodulatory agents (including biologics) or other JAK inhibitor treatment for moderate to severe AD.

◯ **ABROCITINIB** 50 mg, 100 mg, 200 mg **9901-0444**

◯ **Initial**: 50 mg or 100 mg or 200 mg once daily: 6 months

OR ◯ **Renewal**: 50 mg or 100 mg or 200 mg once daily: 1 year

Please note: 50 mg once daily dose is only indicated for use in patients with moderate to severe renal impairment

◯ **UPADACITINIB ER** 15mg, 30 mg **9901-0443**

◯ **Initial**: 15 mg or 30 mg once daily: 6 months

OR ◯ **Renewal**: 15 mg or 30 mg once daily: 1 year

SECTION 4 – CRITERIA FOR INITIAL COVERAGE: 6 MONTHS

PharmaCare coverage is considered when requested by a dermatologist, allergist, or clinical immunologist with expertise in the management of moderate to severe atopic dermatitis in patients 12 years of age and older

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

A. ☐ Patient has a baseline pre-JAK inhibitor Eczema Area and Severity Index (EASI) score $\geq$ 16.

Specify current EASI score (completed within the past 90 days): ______________________ Date EASI conducted: ______________________________

B. ☐ Patient has a baseline pre-JAK inhibitor validated Investigator Global Assessment for Atopic Dermatitis (vIGA-AD) score $\geq$ 3.

Specify current vIGA-AD score (completed within the past 90 days): ______________________ Date vIGA-AD conducted: ______________________________

C. Patient continues to have moderate to severe atopic dermatitis despite an adequate trial of the following therapies:

☐ Maximally tolerated medical topical therapies for AD combined with phototherapy (where available) **AND**

☐ Maximally tolerated medical topical therapies for AD combined with at least **2** of the following systemic immunomodulators for a minimum duration of 3 months at an adequate therapeutic dose:

Medication Trialed	Dosing Regimen Used	Duration of Use	Response to Trial
Methotrexate 10-20 mg weekly (0.2-0.5 mg/kg/week for ages 12-18, or up to usual adult dose)			
Cyclosporine 2.5-5 mg/kg/day			
Mycophenolate mofetil 2-3 g daily (30-40 mg/kg/day for ages 12-18, or up to usual adult dose)			
Azathioprine 1-2.5 mg/kg/day			

PATIENT NAME	PERSONAL HEALTH NUMBER (PHN)	DATE (YYYY / MM / DD)

SECTION 5 – CRITERIA FOR RENEWAL: 1 YEAR

PharmaCare coverage is considered when requested by a dermatologist, allergist, or clinical immunologist with expertise in the management of moderate to severe refractory atopic dermatitis in patients 12 years of age and older

Approval subject to patient having met ALL of the criteria below (Mark boxes and complete blanks as applicable):

A. ☐ The patient has attained and maintained a beneficial clinical effect, defined as a 75% or greater improvement from baseline in the EASI score (EASI-75):

Specify pre-JAK inhibitor EASI score: ______________________

Specify current EASI score (completed within the past 90 days): ________________________ Date EASI conducted: ________________________________

B. Additional Information

SECTION 6 – SWITCHING TO ANOTHER JAK-INHIBITOR: 6 MONTHS

PharmaCare coverage is considered when requested by a dermatologist, allergist, or clinical immunologist with expertise in the management of moderate to severe refractory atopic dermatitis in patients 12 years of age and older

Name and dose of JAK inhibitor being discontinued: ____

Date JAK inhibitor was discontinued: ________________________________ Length of JAK inhibitor trial: ______________________________________

Reason for discontinuation of JAK inhibitor:

◯ Patient failed to achieve an EASI-75

◯ Patient failed to maintain an EASI-75

◯ Other (please specify) ____

Specify current EASI score (completed within the past 90 days): ________________________ Date EASI conducted: ________________________________

SECTION 7 – SPECIALIST SIGNATURE

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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Specialist'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	DURATION OF THERAPY / TERMINATION DATE