BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

ADALIMUMAB FOR NON-INFECTIOUS UVEITIS

HLTH 5854 Rev. 2024/06/19

◯ **INITIAL (Complete sections 1 – 5, and 7 – 8)** ◯ **RENEWAL (Complete sections 1 – 4, and 6 – 8)**

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 →	Ophthalmologist or Rheumatologist 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 Body Weight (kg)	Year of Diagnosis

☐ **ADALIMUMAB**
PharmaCare eligible biosimilar adalimumab brands/strengths

◯ **Initial:**
Pediatric: <30 kg: 20 mg every 2 weeks in combination with methotrexate, if tolerated
≥30 kg: 40 mg every 2 weeks in combination with methotrexate, if tolerated
Initial optional loading dose of 40-80 mg in patients ≥6 years depending on weight
Adult: 80 mg week 0, 40 mg week 1, then 40 mg every 2 weeks

OR ◯ **Renewal:**
Pediatric: <30 kg: 20 mg every 2 weeks in combination with methotrexate, if tolerated
≥30 kg: 40 mg every 2 weeks in combination with methotrexate, if tolerated
Adult: 40 mg every 2 weeks

◯ **Other dosing regimen or alternative request** _____

SECTION 4 – CURRENT NON-INFECTIOUS UVEITIS (NIU) INFORMATION

Please complete information below, as applicable

A. ☐ Type of Uveitis: ◯ Anterior ◯ Intermediate ◯ Posterior ◯ Panuveitis ◯ Other/underlying etiology, if applicable: _____

B. ☐ i. Complete table below providing **CURRENT** measures (completed within the past 180 days) **OR** provide the **CURRENT** ophthalmology consult(s) that include all measures in the table below.

☐ ii. Provide date of assessment (if copy of consult is not provided): _____

		OD	OS
Anterior chamber cell grade (0-4+) **AND/OR**		◯ 0 ◯ 0.5+ ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+	◯ 0 ◯ 0.5+ ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+
Vitreous haze grade (0-4+)		◯ 0 ◯ 0.5+ ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+	◯ 0 ◯ 0.5+ ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+
Best Corrected Visual Acuity (BCVA) Snellen			
NIU flares in past 12 months	Number		
	Duration (months)		
Number of inflammatory lesions			
Other (e.g., central macular thickness if patient has uveitic macular edema. etc.)			

Please complete additional criteria on page 2 →

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

SECTION 5 – CRITERIA FOR INITIAL COVERAGE: 1 YEAR

PharmaCare coverage is considered when requested by an ophthalmologist or rheumatologist with expertise in the management of active non-infectious uveitis (NIU)

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

☐ Patient is 2 years of age or older and continues to have **active** non-infectious uveitis (NIU) despite therapy with a systemic or ophthalmic corticosteroid in combination with at least one non-biologic immunomodulatory agent (methotrexate for pediatric patients 2 to 17 years old) for a minimum duration of 3 months at an adequate therapeutic dose:

Medication Trialed	Details of dosing regimen(s) used - relevant historical information as well as current dosing	Duration of Use	Response to Trial	Is intent to use in combination with adalimumab?
Topical corticosteroid Drug name/concentration:				◯ Yes ◯ No
Systemic corticosteroid Drug name:				◯ Yes ◯ No
Methotrexate 25 mg weekly Ages 2-18: 0.3-0.6 mg/kg/week, up to a maximum of 25 mg weekly				◯ Yes ◯ No
Other:				◯ Yes ◯ No

SECTION 6 – CRITERIA FOR RENEWAL COVERAGE: 1 YEAR

PharmaCare coverage is considered when requested by an ophthalmologist or rheumatologist with expertise in the management of active non-infectious uveitis (NIU)

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 meaningful clinical benefit when compared to baseline

B. ☐ Current medications being used to treat NIU

Medication	Strength (% or mg)	Dosing Regime (including total # drops/day as applicable)

C. ☐ If in remission, is there a possibility of tapering of adalimumab dose or frequency during the next year? ◯ Yes ◯ No If yes, provide the tapering plan:

SECTION 7 – ADDITIONAL INFORMATION (IF APPLICABLE)

SECTION 8 – 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.

Ophthalmologist or Rheumatologist 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

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