Collaborative Prescribing Agreement

dimethyl fumarate, glatiramer acetate, interferon beta-1a, and interferon beta-1b, teriflunomide for the treatment of relapsing-remitting multiple sclerosis

This COLLABORATIVE PRESCRIBING AGREEMENT (the CPA or "Agreement") is entered into by the Medical Beneficiary and Pharmaceutical Services Division, Ministry of Health, B.C., and the undersigned neurologist.

To obtain a neurologist exemption from completing Special Authority requests for dimethyl fumarate (Tecfidera™), glatiramer acetate (Copaxone®), interferon beta-1a (Avonex®), interferon beta-1a (Rebif®), and interferon beta-1b (Betaseron®, Extavia®), teriflunomide (Aubagio™) for relapsing-remitting multiple sclerosis (MS), I, _____, a neurologist specializing in MS who practices at one of the following
(Name of neurologist)
MS clinic locations, □ Fraser Health Multiple Sclerosis Clinic in Burnaby □ Kelowna General Hospital □ MS Clinic at UBC Hospital in Vancouver □ MS Clinic in Prince George □ Vancouver Island MS Clinic at Royal Jubilee Hospital in Victoria, agree to prescribe according to the following Limited Coverage criteria:

Special Authority Criteria	Approval Period
Initial: As monotherapy for the treatment of relapsing-remitting multiple sclerosis (MS) diagnosed according to the current McDonald[i] clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist from a designated MS clinic, for patients who meet **ALL** of the following criteria: 1. Patient has had at least 2 disabling attacks[ii] of MS in the previous 2 years, **AND** 2. Patient is ambulatory with or without aid (EDSS of 6.5 or less), **AND** 3. Patient is 18 years of age or older. Note: i. The McDonald clinical criteria for the diagnosis of MS are current as of October 26, 2010. ii. An attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 24 hours in the absence of fever, and preceded by stability for at least 1 month.	1 year
Renewal: As monotherapy, when prescribed by a neurologist from a designated MS clinic, for the treatment of patients with relapsing-remitting MS who demonstrate that the therapeutic benefits outweigh any potential risks, as shown by relapse rate, EDSS, MRI scan, or overall clinical impression.	1 year
Change of Therapy: As monotherapy, when prescribed by a neurologist from a designated MS clinic, for the treatment of patients with relapsing-remitting MS who have experienced failure or intolerance to a previous disease modifying therapy.	1 year
Additional criteria for interferon beta-1b (Betaseron® and Extavia®): Interferon beta-1b is also eligible for PharmaCare coverage for the treatment of secondary progressive MS (initial, renewal and change of therapy).	1 year

Terms of the Agreement:

- The Medical Beneficiary & Pharmaceutical Services Division reserves the right to modify the Limited Coverage criteria; grant practitioner exemptions from completing Special Authority requests for prescriptions meeting the above Limited Coverage criteria; require renewals of exemptions; and, as necessary, conduct quality assurance checks of such processes. For quality assurance purposes, the neurologist with an exemption agrees to receive feedback on his/her prescribing of dimethyl fumarate (Tecfidera™), glatiramer acetate (Copaxone®), interferon beta-1a (Avonex®), interferon beta-1a (Rebif®), interferon beta-1b (Betaseron®, Extavia®), and teriflunomide (Aubagio™).
- Patients who meet the Limited Coverage criteria and whose prescription is written by a neurologist with a valid exemption will receive automatic Special Authority coverage for subsequent claims up to the specified maximum.
- Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement and any other applicable PharmaCare pricing policy. Each CPA must be signed by the practitioner who is requesting coverage and not a delegate.
- PharmaCare coverage is not retroactive. Special Authority approval or a current exemption must be in place before a patient fills an initial or refill prescription.
- For any patient who does not meet the Limited Coverage criteria, a practitioner with an exemption is required to do one of the following:
  a) Write on the prescription "Submit as zero cost to PharmaCare", to indicate to the pharmacist that the prescription is not to be covered by PharmaCare; or
  b) Apply for exceptional PharmaCare coverage by submitting a Special Authority request with full documentation (via fax to 1-800-609-4884).
- An exemption may be discontinued if the neurologist prescribes dimethyl fumarate, glatiramer acetate, interferon beta-1a, and interferon beta-1b, and teriflunomide in a manner inconsistent with the terms of this Agreement.
  - The practitioner's contact information below will be used only to a) provide feedback to the practitioner on their prescribing of this drug and/or b) communicate changes to the Limited Coverage criteria and/or terms of this Agreement. Contact information will not be shared.

All fields below are mandatory.

Name of neurologist (please print)	
Neurologist signature	College of Physicians & Surgeons ID number
Address (work)	Fax number (to which confirmation of exemption should be sent)
Date submitted	Email

FAX COMPLETED AGREEMENT TO HEALTH INSURANCE BC at 1 250 405-3599

A copy of this agreement will be kept on file at the Ministry of Health.

Medical Beneficiary & Pharmaceutical Services Division Use Only:

Effective date: _____ Approval period: Indefinite Approved on behalf of Medical Beneficiary & Pharmaceutical Services Division: _____ Confirmation sent (date): _____	**DBR Operational Information**: ID reference number for CPSBC = 91 Category and subcategory code = • dimethyl fumarate (Tecfidera™) 9901-0239; • glatiramer acetate (Copaxone®) 9901-0117; • interferon beta-1a (Avonex®) 9901-0118; • interferon beta-1a (Rebif®) 9901-0079; • interferon beta-1b (Betaseron®, Extavia®) 9901-0110 • teriflunomide (Aubagio™) 9901-0246 Assumed SA = No