Print Form

Health PEI

SPECIAL AUTHORIZATION REQUEST

CROHN'S DISEASE

Fax requests to (902) 368-4905 **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8
HIGH COST DRUG PROGRAM PATIENT APPLICATION ALSO REQUIRED PRIOR TO COVERAGE

SECTION 1 – PRESCRIBER INFORMATION

SECTION 2 – PATIENT INFORMATION

NAME AND MAILING ADDRESS	PATIENT (FAMILY NAME)	PATIENT (GIVEN NAME)
	DATE OF BIRTH (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)
PHONE NUMBER (INCLUDE AREA CODE):	PATIENT'S MAILING ADDRESS	
FAX NUMBER (INCLUDE AREA CODE):		

SECTION 3 – MEDICATION AND DETAIL INFORMATION

REQUESTED DRUG AND MEDICAL CONDITION (PLEASE CHECK ONE CONDITION AND DRUG) Approval will NOT be considered in combination with other biologic agents.	PATIENT WEIGHT (kg)

☐ **Moderate to severe active Crohn's Disease**

☐ **Adalimumab** – Initial 12 week approval is for an induction dose of 160 mg followed by 80 mg 2 weeks later, then 40 mg every 2 weeks thereafter.

☐ **Infliximab** – Initial approval is for 3 doses of 5 mg/kg/dose administered at 0, 2 and 6 weeks

MODERATE TO SEVERE CROHN'S CRITERIA - CHECK/FILL OUT RELEVANT BOXES BELOW

☐ **Patient has moderate to severe active Crohn's Disease with a Harvey Bradshaw Index score of 7 or more**

AND

☐ **Patient has not responded to 5-ASA products (minimum trial of 3 grams per day for 6 weeks)**

DRUG	DOSE	DURATION OF TREATMENT

AND

☐ **Patient has not responded to or are intolerant to glucocorticosteroid therapy (e.g. prednisone)**

DRUG	DOSE	DURATION OF TREATMENT

OR

☐ **Treatment discontinued due to serious adverse reactions**

REACTION	DRUG	DOSE	DURATION OF TREATMENT

OR

☐ **Contraindication to use of glucocorticosteroid therapy**

CONTRAINDICATION

AND

☐ **Patient has not responded to immunosuppressive therapy (Azathioprine or Mercaptopurine, or Methotrexate)**

DRUG	DOSE	DURATION OF TREATMENT

OR

☐ **Treatment discontinued due to serious adverse reactions**

REACTION	DRUG	DOSE	DURATION OF TREATMENT

OR

☐ **Contraindication to use of immunosuppressive therapy**

CONTRAINDICATION

SECTION 3 CONTINUED – MEDICATION AND DETAIL INFORMATION

☐ Fistulizing Crohn's Disease

☐ **Infliximab** – Initial approval is for 3 doses of 5 mg/kg/dose administered at 0, 2 and 6 weeks.

FISTULIZING CROHN'S CRITERIA - CHECK/FILL OUT RELEVANT BOXES BELOW

☐ **Patient has Fistulizing Crohn's Disease with a Harvey Bradshaw Index score of 7 or more**

AND

☐ **Patient has actively draining perianal or enterocutaneous fistula(e) that have recurred or persisted despite a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks**

DRUG	DOSE	DURATION OF TREATMENT

AND

☐ **Patient has not responded to immunosuppressive therapy (azathioprine, mercaptopurine or methotrexate)**

DRUG	DOSE	DURATION OF TREATMENT

OR

☐ **Treatment discontinued due to serious adverse reactions**

REACTION	DRUG	DOSE	DURATION OF TREATMENT

OR

☐ **Contraindication to use of immunosuppressive therapy**

CONTRAINDICATION

SECTION 4 – CONTINUED COVERAGE

Coverage will be for a maximum of 12 months. Renewal of coverage will require the achievement and maintenance of a Harvey Bradshaw Index score that is at least a 3 point decrease from baseline and submission of a new Crohn's Disease Special Authorization request.

☐ **Adalimumab** continued coverage will be limited to 40 mg every 2 weeks

☐ **Infliximab** continued coverage will be limited to 5 mg/kg/dose every 8 weeks

Harvey Bradshaw Index score: Baseline:_____ **Most recent:**_____

MONTH AND YEAR BIOLOGIC THERAPY STARTED	CURRENT DOSE AND DOSING INTERVAL		PATIENT'S WEIGHT (KG
CONCURRENT CROHN'S DISEASE THERAPY	**DRUG**	**DOSE**	**FREQUENCY**

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under the PEI High-Cost Drugs Program.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

PRESCRIBER SIGNATURE (REQUIRED) **DATE**

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION. **APRIL 2017 CMC**

APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES