Health PEI

SPECIAL AUTHORIZATION REQUEST

PSORIATIC ARTHRITIS

Fax requests to (902) 368-4905 **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – PRESCRIBER INFORMATION

NAME AND MAILING ADDRESS

PHONE NUMBER (INCLUDE AREA CODE):

FAX NUMBER (INCLUDE AREA CODE):

SECTION 2 – PATIENT INFORMATION

PATIENT (FAMILY NAME)

PATIENT (GIVEN NAME)

DATE OF BIRTH (YYYY/MM/DD)	DATE OF APPLICATION (YYYY/MM/DD)

PERSONAL HEALTH NUMBER (PHN)

SECTION 3 – MEDICATION AND DOSE SELECTION

REQUESTED DRUG (PLEASE CHECK ONE)

- ☐ **Adalimumab** – Maximum coverage is for 40mg every two weeks.
- ☐ **Etanercept** - Maximum coverage is for 50mg weekly or 25mg twice weekly.
- ☐ **Golimumab** - Maximum coverage is for 50mcg once monthly.
- ☐ **Certolizumab** – Maximum coverage is for 400mg at 0, 2 and 4 weeks
- ☐ **Infliximab** – Maximum coverage is for 5mg/kg at 0, 2 and 6 weeks then every 8 weeks thereafter

SECTION A: INITIAL 4 MONTH COVERAGE CRITERIA (USE SECTION B FOR CONTINUED COVERAGE)

- Approvals for anti-TNF agents will **NOT** be considered in combination with other biologic agents.

CHECK/FILL OUT RELEVANT BOXES BELOW:

☐ Medication is being prescribed by a rheumatologist **AND**

Patient must have at least three active and tender joints __________ # of joints **AND**

DAS28 Score__________ Date: ___________________ **OR**

HAQ Score __________ Date: ____________________ **AND**

☐ Patient has not responded to an adequate trial with two DMARDs at optimal dose or has an intolerance or contraindication to a DMARD:

DMARD	DOSE	FREQUENCY	LENGTH OF TX

DMARD CONTRAINDICATION/INTOLERANCE (REASON/DESCRIBE):

SECTION B: CONTINUED COVERAGE

-Coverage will be for a maximum of 12 months. Renewal of coverage will require reassessment of the patient and submission of a new Psoriatic Arthritis Special Authorization Request Form.

- Reassessment for coverage is dependent on patient receiving an improvement of at least **20% (ACR20)** or response using the Psoriatic Arthritis Response Criteria:

CHECK/FILL OUT RELEVANT BOXES BELOW:

DAS28 Score ____________ Date: ___________________ **OR**

ACR20 Score ____________ Date: ___________________ **OR**

HAQ Score ____________ Date: ___________________

CURRENT THERAPY (PLEASE CHECK ONE)	DOSAGE AND FREQUENCY	WEIGHT (KG)
☐ **Adalimumab** ☐ **Etanercept** ☐ **Golimumab** ☐ **Certolizumab** ☐ **Infliximab**		

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.

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