Health PEI

SPECIAL AUTHORIZATION REQUEST

RHEUMATOID 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

☐ **Abatacept** – Maximum adult coverage is for 500mg for patients <60kg , 750mg for patients 60 to 100kg, 1000mg for patients >100kg given at 0,2,4,8 weeks and every 4 weeks thereafter. Pediatric patients 6-17 years of age and < 75kg, coverage is for 10mg/kg based on weight at administration (pediatric patients >75kg to be treated at adult dose) given at 0,2,4,8 weeks and every 4 weeks thereafter.

☐ **Adalimumab** – Maximum coverage is for 40mg every two weeks

☐ **Certolizumab** – Maximum coverage is for 400mg (given as two subcutaneous injections of 200mg) given at 0,2,4 weeks then 200mg every 2 weeks (or 400mg every 4 weeks) thereafter.

☐ **Etanercept** – Maximum coverage is for 50mg weekly or 25mg twice weekly. Pediatric patients 4-17 years of age , coverage is 0.8mg/kg weekly to a maximum of 50mg weekly

☐ **Golimumab** – Maximum coverage is for 50mg once monthly

☐ **Infliximab** – Maximum coverage is for 3mg/kg/dose at 0, 2 and 6 weeks, then every 8 weeks thereafter

☐ **Tocilizumab** – ***IV formulation***: Maximum adult coverage is 4 mg/kg/dose every 4 weeks, with a maximum maintenance dose escalation up to 8/mg/kg to a maximum of 800 mg per infusion.

– ***SC formulation***: Maximum coverage for adults is 162 mg every other week for patients <100kg with a maximum maintenance dose escalation to 162 mg weekly. For patients >100kg maximum coverage is 162 mg every week with no dose escalation permitted.

☐ **Rituximab** – fill out section 4

SECTION A: INITIAL 6 MONTH COVERAGE CRITERIA

- Approval for anti-tnf agents will **NOT** be considered with other biologic agents

CHECK RELEVANT BOXES BELOW:

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

☐ Biologic will be used in combination with methotrexate or other DMARD

☐ Patient is refractory or intolerant to methotrexate (oral or parenteral) at a dose of ≥ 20mg weekly (≥ 15mg if patient is ≥ 65 years of age), (or in combination with another DMARD) for a minimum of 12 weeks **AND**

☐ Patient is refractory or intolerant to methotrexate in combination with at least two other DMARDs for a minimum of 12 weeks

SECTION B: CONTINUED COVERAGE

Coverage is for a maximum of 12 months. Renewal will require reassessment of the patient and submission of a new Rheumatoid Arthritis Special Authorization request form.

PLEASE CHECK THE RELEVANT BOX BELOW:

Continued response to biologic agent ☐ YES ☐ NO

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

SECTION 4 – ALTERNATE BIOLOGIC (RITUXIMAB)

REQUESTED COVERAGE

For treatment of adult patients with severe active rheumatoid arthritis who have failed to respond to an adequate trial with an anti-TNF agent. Rituximab will not be considered in combination with other biologic agents.

SECTION A:

Please check the relevant boxes below:

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

☐ Patient has failed to respond to an adequate trial of an anti-TNF agent

PRIOR BIOLOGICS AND REASON FOR DISCONTINUATION OR CONTRAINDICATIONS TO OTHER BIOLOGICS		
NAME, DOSE & FREQUENCY	DURATION (PLEASE SPECIFY DATES)	SIDE EFFECTS OR CONTRAINDICATIONS – PLEASE SPECIFY

SECTION B:

☐ **Rituximab – Initial Coverage, two courses**

Each course is 1000mg at 0 & 2 weeks, minimum of 24 weeks between courses

☐ **Rituximab – Renewal, two courses**

Each course is 1000mg at 0 & 2 weeks, minimum of 24 weeks between courses

Patient achieved initial response **followed by a subsequent loss of effect** ☐ Yes ☐ No

Date of last Rituximab infusion:

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**

JUNE 2017/CMC

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.

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