Health PEI

MEDICAL SCREENING FORM

MULTIPLE SCLEROSIS

Fax requests to (902) 838-0940 **OR** mail requests to PEI MS Medications Program, P.O. Box 3000, Montague, PE, C0A 1R0

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)	PATIENT (FAMILY) NAME	PATIENT (GIVEN) NAME(S)

DATE OF BIRTH (YYYY/MM/DD)	PATIENT'S MAILING ADDRESS
| |	

SECTION 2 – NEUROLOGIST INFORMATION

NAME AND MAILING ADDRESS	ASSESSMENT DATE YYYY MM DD | |
	PRESCRIBER'S TELEPHONE # |
	PRESCRIBER'S FAX # |

FAMILY PHYSICIAN NAME AND ADDRESS:

SECTION 3 – CONDITION DETAIL INFORMATION

GUIDELINES FOR PROGRAM (check relevant boxes below):

- ☐ Relapsing-Remitting MS
- ☐ Secondary Progressing MS
- ☐ Two attacks in the last year
- ☐ Patient is at least 18 years of age
- ☐ EDSS score of 6.5 or less

DATE OF ASSESSMENT (YYYY/MM/DD)_____

CONTRAINDICATIONS FOR PROGRAM (check relevant boxes below):

- ☐ Concurrent illness to alter compliance or substantially reduce life expectancy
- ☐ Pregnancy is planned or occurs, nursing women
- ☐ Active severe depression, as defined by DSM V

COMMENTS:

Clients who meet the above criteria will be eligible to receive **Glatiramer, Interferon Beta-1A, Interferon Beta-1B, Teriflunomide, Dimethyl fumarate, or Peginterferon Beta-1A**

For Fingolimod requests, please refer to **SECTION 4.**

SECTION 4 – FINGOLIMID (GILENYA) COVERAGE REQUEST

SECTION A: INITIAL ADULT APPROVAL IS FOR 0.5 MG DAILY FOR UP TO 12 MONTHS

INITIAL APPROVAL CRITERIA:

For the treatment of patients with Relapsing-Remitting Multiple Sclerosis (RRMS) who meet **all** of the following criteria:

1. Has been on a trial of at least 6 months of Interferon or Glatiramer ☐ **YES** ☐ **NO**

NAME OF DRUG:	DURATION OF TREATMENT:

2. Has contraindications to **OR** has failed to respond* to full and adequate treatment with Interferon AND Glatiramer ☐ **YES** ☐ **NO**
   *Response failure defined as at least one disabling attack while on Interferon or Glatiramer
3. Has experienced one or more clinically disabling relapses in the previous year ☐ **YES** ☐ **NO**
4. Has significant increase in T2 lesion load compared with that from a previous MRI scan (i.e. 3 or more new lesions) or at least one gadolinium-enhancing lesion (include MRI reports) ☐ **YES** ☐ **NO**
5. Has a recent Expanded Disability Status Scale (EDSS) **score of less than or equal to 5.5** ☐ **YES** ☐ **NO**
   Date of EDSS (YYYY/MM/DD)_____

EXCLUSION CRITERIA:

1. Is the client on other disease modifying therapies (Avonex, Betaseron, Copaxone, Extavia, Tysabri or Fampyra)? ☐ **YES** ☐ **NO**
2. Has the client had a heart attack or stroke within 6 months of funding request, or have a history of sick sinus syndrome, AV block, significant QT prolongation, bradycardia, ischemic heart disease, or congestive heart failure? ☐ **YES** ☐ **NO**

SECTION B: RENEWAL PERIOD IS FOR 12 MONTHS

1. Patient is stable and has experienced no more than one disabling relapse in the past year ☐ **YES** ☐ **NO**

Expanded Disability Status Scale score:_____

Date of EDSS (YYYY/MM/DD) _____

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.

NEUROLOGIST 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