

SPECIAL AUTHORIZATION REQUEST FOR COVERAGE OF HIGH COST CANCER DRUGS

(Vemurafenib, Abiraterone, Enzalutamide)

Part 1 - Patient Information

PEI Pharmacare

Patient's Name (last name, first name, middle initial)				
Provincial Health Number	Date of Birth (DD/MM/YYYY)	Sex:	Male	Female
When patient available, please complete: refer to FOIPP				
I authorize the prescriber to release information to PEI Pharmacare related to this Special Authorization Request.				
Patients Signature (optional):			Date:	

Part 2 - Physician Information (Must be requested & prescribed by specialist in hematology or medical oncology, or a general practitioner acting under direction of those specialists)

Name	Telephone #
Mailing Address	Fax #
The PEI Pharmacare Program 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 Drug Program. If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947, toll free # 1-877-577-3737 or at the address below.	
Physician's Signature:	Date:

To send completed Special Authorization Request or to obtain further information, please contact:

High Cost Drug Program
PEI Pharmacare, Sullivan Building
P.O. Box 2000, 20 Fitzroy St.
Charlottetown, PE C1A 7N8
Telephone: 1-902-368-4947 Toll Free # 1-877-577-3737
Fax: 1-902-368-4905

Drug Program Use Only

Accepted for Coverage (state dosage and anticipated dosing frequency): _____

Rejected for Coverage (state reason): _____

Effective Date (DD/MM/YYYY):

Termination Date (DD/MM/YYYY):

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Please note that the patient must also complete a copy of the High Cost Drug Program application form and return it and all required financial information to the PEI Pharmacare Office.

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The above named applicant meets the following medical criteria for coverage of the medication selected below (please check the relevant box)at the dosing regime specified:

VEMURAFENIB (ZELBORAF) - Coverage will be approved for a maximum of 12 months at one time.	
Indicate Dosing Regime (required):	
<input type="checkbox"/>	Metastatic Melanoma (first line) - for BRAF V600 mutation positive unresectable or metastatic melanoma in patients with an ECOG performance status (PS) of 0 or 1.
<input type="checkbox"/>	Metastatic Melanoma (second line) - for BRAF V600 mutation positive patients who have progressed after first line treatment prior to vemurafenib availability

ABIRATERONE ACETATE (ZYTIGA) - Coverage will be approved for a maximum of 12 months at one time.	
Indicate Dosing Regime (required):	
<input type="checkbox"/>	Metastatic Prostate Cancer - In combination with prednisone for the treatment of metastatic prostate cancer (castration-resistant prostate cancer) in patients who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy, or have received prior chemotherapy containing docetaxel after failure of androgen deprivation therapy.

ENZALUTAMIDE (XTANDI) - Coverage will be approved for a maximum of 12 months at one time.	
Indicate Dosing Regime (required):	
<input type="checkbox"/>	Metastatic Prostate Cancer - For treatment of patients with metastatic castration resistant prostate cancer, who have progressed on docetaxel-based chemotherapy with an ECOG performance status ≤ 2 and no risk factors for seizures and would be an alternative to abiraterone for patients in the post-docetaxel setting but would not be an add-on therapy to abiraterone treatment.

Please note that the patient must also complete a copy of the High Cost Drug Program application form and return it and all required financial information to the PEI Pharmacare Office.