SPECIAL AUTHORIZATION REQUEST

CROHN'S DISEASE

Fax requests to (902) 368-4905 OR email to drugprograms@gov.pe.ca

HIGH COST DRUG PROGRAM PATIENT APPLICATION ALSO REQUIRED PRIOR TO COVERAGE

Incomplete forms will be returned for completion. If a mailing address and fax number are not provided, we will be unable to issue a response. Approvals will not be considered at doses or dosing intervals outside of PEI guidelines.

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)	PERSONAL HEALTH NUMBER (PHN)
PATIENT'S MAILING ADDRESS	

SECTION 3 – MEDICATION, DOSE & COVERAGE CRITERIA

☐ **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.

☐ **Risankizumab** – Initial approval for IV doses of 600mg at 0, 4 and 8 weeks.

☐ **Upadacitinib** – Initial 16 week approval is for 45 mg daily for 12 weeks, followed by a maximum of 30 mg daily thereafter.

☐ **Ustekinumab*** – Initial 16 week approval is for a single IV dose of up to 520 mg at week 0 and a subcutaneous dose of 90 mg at week 8 and 16.

☐ **Vedolizumab** – Initial approval is for 300 mg administered at 0, 2 and 6 weeks.

*** Approved requests will be for a biosimilar product**

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

Patient's weight (kg): _____

☐ **Patient has moderate to severe active Crohn's Disease and is refractory to, intolerant of, or has contraindications to:**

☐ **Prednisone 40mg (or equivalent) daily ≥ 2 weeks (not required for treatment of Fistulizing Crohn's Disease)**

DRUG	DOSE	DURATION OF TREATMENT
If intolerance or contraindicated, please describe:		

AND

☐ **Azathioprine ≥ 2mg/kg/day for ≥ 3 months**

DRUG	DOSE	DURATION OF TREATMENT
If intolerance or contraindicated, please describe:		

OR

☐ **Mercaptopurine ≥ 1mg/kg/day for ≥ 3 months**

DRUG	DOSE	DURATION OF TREATMENT
If intolerance or contraindicated, please describe:		

OR

☐ **Methotrexate (SC or IM) ≥ 15mg/week for ≥ 3 months**

DRUG	DOSE	DURATION OF TREATMENT
If intolerance or contraindicated, please describe:		

SECTION 4 – CONTINUED COVERAGE

Coverage will be for a maximum of 12 months, except for **biosimilars***, which will be set up for long term coverage.

Renewal of coverage will require confirmation of continued response. _____

- ☐ **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
- ☐ **Risankizumab** continued coverage will be limited to 360mg subcutaneously at Week 12, and every 8 weeks thereafter
- ☐ **Upadacitinib** continued coverage will be limited to 30 mg daily
- ☐ **Ustekinumab*** continued coverage will be limited to 90 mg subcutaneously every 8 weeks
- ☐ **Vedolizumab** continued coverage will be limited to 300 mg every 8 weeks

Patient's weight (kg): _____

Special Authorization grants coverage to a drug that otherwise would not be eligible for coverage. Coverage is provided to patients in specific medical circumstances as defined in the PEI Pharmacare Formulary and **subject to Pharmacare Drug Program plan rules, including deductible and eligibility requirements.**

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 Drug Program. If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947.

PRESCRIBER SIGNATURE (REQUIRED) **DATE**