SPECIAL AUTHORIZATION REQUEST
ANKYLOSING SPONDYLITIS

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

HIGH COST DRUG PROGRAM PATIENT APPLICATION ALSO REQUIRED PRIOR TO COVERAGE

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

- ☐ Adalimumab - Maximum coverage is for 40 mg given every two weeks
- ☐ Etanercept - Maximum adult coverage is for 50 mg weekly or 25mg twice weekly
- ☐ Golimumab - Maximum adult coverage is for 50 mg once monthly
- ☐ Infliximab - Maximum adult coverage is for 5 mg/kg/dose at 0, 2 and 6 weeks, then every 6-8 weeks
- ☐ Certolizumab - Maximum adult coverage is for 400 mg at 0, 2 and 4 weeks, then 200mg every two weeks or 400mg monthly
- ☐ Secukinumab - Maximum adult coverage is for 150 mg at 0,1,2 and 3 weeks, then 150mg monthly starting at week 4
- ☐ Upadacitinib – Maximum adult coverage is for 15 mg once daily

SECTION A: INITIAL 6 MONTH COVERAGE CRITERIA (USE SECTION B FOR CONTINUED COVERAGE)

- Approval 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**

- BASDAI score _____ **AND**

☐ Axial Symptoms (patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to Axial disease do not require a trial of NSAIDs alone)

Patient has not responded to the sequential use of 2 or more NSAIDs at optimal dose for a minimum of 3 months or NSAIDs are contraindicated:

	Please SPECIFY NSAID	Please SPECIFY dose, duration and frequency
NSAID 1		
NSAID 2		
NSAID contraindication (Reason/Describe)		

OR

☐ Peripheral Symptoms

Patient has not responded to the sequential use of 2 or more NSAIDs at optimal dose for a minimum of 3 months (identify in the above table) or NSAIDs are contraindicated AND patient had an inadequate response to an optimal or maximal tolerated dose of a DMARD

	Please SPECIFY DMARD	Please SPECIFY dose, duration and frequency
DMARD 1		
DMARD 2		

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 Ankylosing Spondylitis Special Authorization Request Form.

CHECK/FILL OUT RELEVANT BOXES BELOW

- BASDAI Score _____ (must be at least 2 points below pre-treatment score); **OR**
- Provide evidence of significant functional improvement (e.g., HAQ score)_____

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

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 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 **Dec 2024/BB**