

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

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

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)

- Certolizumab Adalimumab Infliximab
- Etanercept Golimumab

DOSAGE AND FREQUENCY

WEIGHT (KG)

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