Health PEI

SPECIAL AUTHORIZATION REQUEST

PLAQUE PSORIASIS

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

SECTION 1 – PRESCRIBER INFORMATION

SECTION 2 – PATIENT INFORMATION

NAME AND MAILING ADDRESS	PATIENT (FAMILY NAME)	PATIENT (GIVEN NAME)
	DATE OF BIRTH (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)
PHONE NUMBER (INCLUDE AREA CODE):	PATIENT'S MAILING ADDRESS	
FAX NUMBER (INCLUDE AREA CODE):		

SECTION 3 – BACKGROUND DIAGNOSTIC INFORMATION

Diagnosis: Patient has chronic moderate to severe plaque psoriasis as defined by:

- ☐ Body Surface Area (BSA) involvement > 10% **AND/OR**
- ☐ Significant involvement of the face, hands, feet, or genitalia region

SECTION 4 – MEDICATION AND DOSE SELECTION

☐ **Adalimumab** Dose _____

- ☐ initial adult approval (max 16 weeks; 80 mg week 0, 40 mg week1, then 40 mg every two weeks starting on week 2)
- ☐ continued coverage (max dose 40mg every 2 weeks)

☐ **Brodalumab** Dose _____

- ☐ initial adult approval (max 16 weeks; 210 mg at 0, 1 and 2 weeks then 210 mg every two weeks)
- ☐ continued coverage (max dose 210 mg every 2 weeks)

☐ **Etanercept** Dose _____

- ☐ initial adult approval (max 12 weeks; 50mg twice weekly)
- ☐ continued coverage (max dose 50mg weekly)

☐ **Infliximab** Dose _____ Patient wt.(kg)_____

- ☐ initial adult approval (max 12 weeks; 5mg/kg at 0, 2 and 6 weeks then every 8 weeks)
- ☐ continued coverage (max dose 5mg/kg every 8 weeks)

☐ **Ixekizumab** Dose _____

- ☐ initial adult approval (max 12 weeks; 160 mg at week 0, then 80 mg at weeks 2, 4, 6, 8, 10 and 12)
- ☐ continued coverage (max dose 80 mg every 4 weeks)

☐ **Secukinumab** Dose _____

- ☐ initial adult approval (max 12 weeks; 300 mg at weeks 0, 1, 2, and 3, then monthly at week 4)
- ☐ continued coverage (max dose 300 mg monthly)

☐ **Ustekinumab** Dose _____

- ☐ initial adult approval (max 16 weeks; up to 90mg at 0,4, and 16 weeks)
- ☐ continued coverage (max dose 90mg every 12 weeks)

SECTION 5 – PREVIOUS THERAPIES

Patient's Previous Therapies (if completed on a previous request, provide update information only):

Agents Tried: Length of Therapy & Outcome (i.e., intolerant, not effective, etc.)

☐ **Methotrexate** _____

☐ **Cyclosporine** _____

☐ **Phototherapy** _____

SECTION 6 – RENEWAL OF COVERAGE

Pre- Biologic PASI score _____

Current PASI score _____ (or attach copy of completed PASI form)

First renewal after the initial 12 to 16 week trial of biologic:

☐ Patient has obtained a PASI ≥75 from the baseline biologic naïve PASI score or a PASI ≥ 50 with a ≥5 point improvement in the DLQI

Subsequent renewals for maintenance therapy:

☐ Patient has maintained a PASI ≥75 from the baseline biologic naïve PASI score or a PASI ≥ 50 with a ≥5 point improvement in the DLQI

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.

APRIL 2019/CMC

APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES