SPECIAL AUTHORIZATION REQUEST

PLAQUE PSORIASIS

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

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 severe, debilitating chronic plaque psoriasis as defined by:

☐ Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals.

SECTION 4 – MEDICATION AND DOSE SELECTION

☐ **Adalimumab*** Dose _____
- ☐ initial adult approval (max 16 weeks; 80 mg week 0, 40 mg week 1, then 40 mg every two weeks starting on week 2)
- ☐ continued coverage (max dose 40mg every 2 weeks)

☐ **Bimekizumab** Dose _____
- ☐ initial adult approval (max 16 weeks; 320 mg at week 0, 4, 8, 12, and 16)
- ☐ continued coverage (max dose 320 mg every 8 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)

☐ **Guselkumab** Dose _____
- ☐ initial adult approval (max 16 weeks; 100 mg at week 0, 4 and 12)
- ☐ continued coverage (max dose 100 mg every 8 weeks)

☐ **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)

☐ **Risankizumab** Dose _____
- ☐ initial adult approval (max 16 weeks; 150 mg at 0,4 and 12 weeks)
- ☐ continued coverage (max dose 150 mg every 12 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)

☐ **Tildrakizumab** Dose _____
- ☐ initial adult approval (max 16 weeks; 100 mg at week 0, 4, and 12 weeks)
- ☐ continued coverage (max dose 100 mg every 12 weeks)

☐ **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)

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

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** _____

(For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered)

☐ **Cyclosporine** _____

☐ **Phototherapy** _____

SECTION 6 – RENEWAL OF COVERAGE

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

Pre-Biologic PASI score _____
Current PASI score _____ (or attach copy of completed PASI form)
Pre-Biologic DLQI _____
Current DLQI _____

FIRST RENEWAL AFTER THE INITIAL 12 TO 16 WEEK TRIAL OF BIOLOGIC:

☐ Patient has obtained a >75% reduction (provide baseline and current score) in the Psoriasis Area and Severity Index (PASI) score; OR

☐ Patient has obtained a >50% reduction (provide baseline and current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); OR

☐ Patient has obtained a significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

SUBSEQUENT RENEWALS FOR MAINTENANCE THERAPY:

☐ Patient has maintained a >75% reduction (provide current score) in the Psoriasis Area and Severity Index (PASI) score; OR

☐ Patient has maintained a >50% reduction (provide current score) in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); OR

☐ Patient has maintained a significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals.

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. Feb 2025/BB

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