

Fax requests to (902) 368-4905 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 – MEDICATION AND DETAIL INFORMATION

REQUESTED DRUG AND MEDICAL CONDITION (PLEASE CHECK ONE CONDITION AND DRUG) Approval will NOT be considered in combination with other biologic agents.	PATIENT WEIGHT (kg)
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MODERATE TO SEVERE ACTIVE CROHN'S DISEASE

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

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

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

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

Prednisone 40mg (or equivalent) daily \geq 2 weeks

DRUG	DOSE	DURATION OF TREATMENT

If intolerance or contraindicated, please describe:

AND

Azathioprine \geq 2mg/kg/day for \geq 3 months

DRUG	DOSE	DURATION OF TREATMENT

If intolerance or contraindicated, please describe:

OR

Mercaptopurine \geq 1mg/kg/day for \geq 3 months

DRUG	DOSE	DURATION OF TREATMENT

If intolerance or contraindicated, please describe:

OR

Methotrexate (SC or IM) \geq 15mg/week for \geq 3 months

DRUG	DOSE	DURATION OF TREATMENT

If intolerance or contraindicated, please describe:

SECTION 3 CONTINUED – MEDICATION AND DETAIL INFORMATION **FISTULIZING CROHN'S DISEASE** **Infliximab** – Initial approval is for 3 doses of 5 mg/kg/dose administered at 0, 2 and 6 weeks.**FISTULIZING CROHN'S CRITERIA - CHECK/FILL OUT RELEVANT BOXES BELOW** Patient has Fistulizing Crohn's Disease with a Harvey Bradshaw Index score of 7 or more**AND** Patient has actively draining perianal or enterocutaneous fistula(e) that have recurred or persisted despite a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks)

DRUG	DOSE	DURATION OF TREATMENT

AND Patient has not responded to immunosuppressive therapy (azathioprine, mercaptopurine or methotrexate)

DRUG	DOSE	DURATION OF TREATMENT

OR Treatment discontinued due to serious adverse reactions

REACTION	DRUG	DOSE	DURATION OF TREATMENT

OR Contraindication to use of immunosuppressive therapy

CONTRAINDICATION

SECTION 4 – CONTINUED COVERAGE

Coverage will be for a maximum of 12 months.

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
- Vedolizumab** continued coverage will be limited to 300 mg every 8 weeks

Patient's 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 Drug 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**