

## SPECIAL AUTHORIZATION REQUEST CROHN'S DISEASE

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 D	ETAIL INFORMATI	ON		
REQUESTED DRUG AND MEDICAL CONDITION (PLEASE CHECK ONE CONDITION Approval will NOT be considered in combination with other biologic agents.		N AND DRUG) PATIENT WEIGHT (kg)		
☐ MODERATE TO SEVERE ACTIVE CR	OHN'S DISEASE			
Adalimumab – Initial 12 week approva	l is for an induction dose	of 160 mg fo	llowed by 80 m	g 2 weeks later, then 40 mg every 2
weeks thereafter.				
☐ Infliximab – Initial approval is for 3 dos	es of 5 mg/kg/dose admir	nistered at 0,	2 and 6 weeks	<b>:</b>
☐ <b>Vedolizumab</b> – Initial approval is for 30	00 mg administered at 0, 2	2 and 6 week	(S	
MODERATE TO SEVERE CROHN'S CRITER	IA - CHECK/FILL OUT	RELEVANT	BOXES BELO	W
☐ Patient has moderate to severe active C	rohn's Disease and is re	efractory to.	intolerant of	or has contraindications to:
rations mad moderate to covere delive o		muotory to,	intolorant oi,	or nuo communications to:
☐ Prednisone 40mg (or equivalent) daily ≥	2 weeks			
☐ Prednisone 40mg (or equivalent) daily ≥  DRUG	2 weeks  DOSE		DURA	ATION OF TREATMENT
			DURA	ATION OF TREATMENT
	DOSE		DURA	ATION OF TREATMENT
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DRUG  If intolerance or contraindicated, please desc  AND  Azathioprine ≥ 2mg/kg/day for ≥ 3 month	DOSE ribe:			
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DRUG  If intolerance or contraindicated, please description  Azathioprine ≥ 2mg/kg/day for ≥ 3 month  DRUG  If intolerance or contraindicated, please description  OR  Mercaptopurine ≥ 1mg/kg/day for ≥ 3	DOSE ribe:  DOSE ribe: 3 months	DURA	DURA	ATION OF TREATMENT
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## **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 DURATION OF TREATMENT** DOSE 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 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.

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.

APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS QUITSIDE OF PELGUIDELINES.

PRESCRIBER SIGNATURE (REQUIRED)

DATE