

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 adult coverage is for 40mg every two weeks.
- Etanercept** - Maximum adult coverage is for 50mg weekly or 25mg twice weekly.
- Golimumab** - Maximum adult coverage is for 50mcg once monthly.
- Certolizumab** - Maximum adult coverage is for 400mg at 0, 2 and 4 weeks, then 200mg every 2 weeks thereafter.
- Infliximab** - Maximum adult coverage is for 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.
- Ixekizumab** – Maximum adult coverage is for 160 mg at week 0, then 80 mg every 4 weeks.
- Secukinumab** - Maximum adult coverage is for 150 mg at 0, 1, 2 and 3 weeks, then 150 mg monthly starting at week 4.
  - If a patient is an anti-TNF alpha inadequate responder and continues to have active psoriatic arthritis, consider using the 300 mg SC dose. For psoriatic arthritis patients with coexistent moderate to severe plaque psoriasis, use the dosing and administration recommendations for plaque psoriasis (i.e. 300 mg SC at weeks 0, 1, 2, and 3, followed by monthly maintenance dosing starting at week 4).

#### SECTION A: INITIAL 4 MONTH COVERAGE CRITERIA (USE SECTION B FOR CONTINUED COVERAGE)

- Approvals 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**  
 Patient must have at least three active and tender joints \_\_\_\_\_ # of joints **AND**  
 DAS28 Score \_\_\_\_\_ Date: \_\_\_\_\_ **OR**  
 HAQ Score \_\_\_\_\_ Date: \_\_\_\_\_ **AND**

Patient has not responded to an adequate trial with two DMARDs at optimal dose or has an intolerance or contraindication to a DMARD:

DMARD	DOSE	FREQUENCY	LENGTH OF TX

DMARD CONTRAINDICATION/INTOLERANCE (REASON/DESCRIBE):

#### 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 Psoriatic Arthritis Special Authorization Request Form.

- Reassessment for coverage is dependent on patient receiving an improvement of at least **20% (ACR20)** or response using the Psoriatic Arthritis Response Criteria:

##### CHECK/FILL OUT RELEVANT BOXES BELOW:

- DAS28 Score \_\_\_\_\_ Date: \_\_\_\_\_ **OR**
- ACR20 Score \_\_\_\_\_ Date: \_\_\_\_\_ **OR**
- HAQ Score \_\_\_\_\_ Date: \_\_\_\_\_

#### CURRENT THERAPY (PLEASE CHECK ONE)

- Adalimumab**    **Etanercept**
- Golimumab**    **Certolizumab**    **Infliximab**

#### 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**