SPECIAL AUTHORIZATION REQUEST

PSORIATIC ARTHRITIS

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

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.
- ☐ **Certolizumab** - Maximum adult coverage is for 400mg at 0, 2 and 4 weeks, then 200mg every 2 weeks thereafter.
- ☐ **Etanercept** - Maximum adult coverage is for 50mg weekly or 25mg twice weekly.
- ☐ **Golimumab** - Maximum adult coverage is for 50mcg once monthly.
- ☐ **Guselkumab** - Maximum adult coverage is for 100 mg every 8 weeks.
- ☐ **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.
- ☐ **Upadacitinib** - Maximum adult coverage is for 15mg daily.
- ☐ **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 16 WEEK COVERAGE CRITERIA (USE SECTION B FOR CONTINUED COVERAGE)

CHECK/FILL OUT RELEVANT BOXES BELOW:

☐ Medication is being prescribed by a rheumatologist **AND**

☐ For the treatment of **predominantly axial psoriatic arthritis** who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs for a minimum of two weeks each.

NSAID	DOSE	FREQUENCY	LENGTH OF TX
NSAID contraindication/intolerance (reason/describe):			

☐ For the treatment of **predominantly peripheral psoriatic arthritis** who are refractory or intolerant to:

☐ Sequential use of at least two NSAIDs for a minimum of two weeks each; **AND**

NSAID	DOSE	FREQUENCY	LENGTH OF TX
NSAID contraindication/intolerance (reason/describe):			

☐ Methotrexate (oral or parenteral*) at a dose of ≥ 20mg weekly (≥15mg if patient is ≥65 years of age) for a minimum of 8 weeks; **AND**

☐ Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months.

**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.*

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.

☐ Confirmation of continued response

CURRENT THERAPY:	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**

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.

APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES **MARCH 2024/CM**