Health PEI

SPECIAL AUTHORIZATION REQUEST

RHEUMATOID ARTHRITIS

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)	PATIENT WEIGHT (KG)
PERSONAL HEALTH NUMBER (PHN)	

SECTION 3 – MEDICATION AND DOSE SELECTION

☐ **Abatacept** – ***IV formulation:*** Maximum adult coverage is for 500mg for patients <60kg , 750mg for patients 60 to 100kg, 1000mg for patients >100kg given at 0,2,4,8 weeks and every 4 weeks thereafter. Pediatric patients 6-17 years of age and < 75kg, coverage is for 10mg/kg based on weight at administration (pediatric patients >75kg to be treated at adult dose) given at 0,2,4,8 weeks and every 4 weeks thereafter.

☐ **Abatacept** – ***SC formulation:*** For adult abatacept-naive patients, a single loading dose of up to 1000mg, then 125 mg sc injection given within a day, and once weekly thereafter.

☐ **Adalimumab** – Maximum coverage is for 40mg every two weeks.

☐ **Certolizumab** – Maximum adult coverage is for 400mg (given as two subcutaneous injections of 200mg) given at 0,2,4 weeks then 200mg every 2 weeks (or 400mg every 4 weeks) thereafter.

☐ **Etanercept** – Maximum coverage is for 50mg weekly. Pediatric patients 4-17 years of age , coverage is 0.8mg/kg weekly to a maximum of 50mg weekly.

☐ **Golimumab** – Maximum adult coverage is for 50mg once monthly.

☐ **Infliximab** – Maximum adult coverage is for 3mg/kg/dose at 0, 2 and 6 weeks, then every 8 weeks thereafter.

☐ **Sarilumab** – Maximum adult dosage is 200 mg every 2 weeks.

☐ **Tocilizumab** – ***IV formulation***: Maximum adult coverage is 4 mg/kg/dose every 4 weeks, with a maximum maintenance dose escalation up to 8/mg/kg to a maximum of 800 mg per infusion.

☐ **Tocilizumab** – ***SC formulation***: Maximum adult coverage is 162 mg every other week for patients <100kg with a maximum maintenance dose escalation to 162 mg weekly. For patients >100kg maximum coverage is 162 mg every week with no dose escalation permitted.

☐ **Tofactinib** – Maximum adult coverage is for 5 mg twice daily

☐ **Tofactinib XR** – Maximum adult coverage is for 11 mg once daily

☐ **Rituximab** – fill out section 4.

SECTION A: INITIAL 6 MONTH COVERAGE CRITERIA

CHECK RELEVANT BOXES BELOW:

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

☐ Patient is refractory or intolerant to methotrexate (oral or parenteral) at a dose of ≥ 20mg weekly (≥ 15mg if patient is ≥ 65 years of age), (or in combination with another DMARD) for a minimum of 12 weeks **AND**

☐ Patient is refractory or intolerant to methotrexate in combination with at least two other DMARDs for a minimum of 12 weeks

SECTION B: CONTINUED COVERAGE

Coverage is for a maximum of 12 months. Renewal will require reassessment of the patient and submission of a new Rheumatoid Arthritis Special Authorization request form.

PLEASE CHECK THE RELEVANT BOX BELOW:

Continued response to biologic agent ☐ YES ☐ NO

CURRENT THERAPY (PLEASE CHECK ONE)	**DOSAGE AND FREQUENCY**
☐ Abatacept ☐ Adalimumab ☐ Certolizumab ☐ Etanercept ☐ Golimumab ☐ Infliximab ☐ Tocilizumab ☐ Tofactinib	

SECTION 4 – ALTERNATE BIOLOGIC (RITUXIMAB)

REQUESTED COVERAGE

For treatment of adult patients with severe active rheumatoid arthritis who have failed to respond to an adequate trial with an anti-TNF agent. Rituximab will not be considered in combination with other biologic agents.

SECTION A:

Please check the relevant boxes below:

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

☐ Patient has failed to respond to an adequate trial of an anti-TNF agent

PRIOR BIOLOGICS AND REASON FOR DISCONTINUATION OR CONTRAINDICATIONS TO OTHER BIOLOGICS		
NAME, DOSE & FREQUENCY	DURATION (PLEASE SPECIFY DATES)	SIDE EFFECTS OR CONTRAINDICATIONS – PLEASE SPECIFY

SECTION B:

☐ **Rituximab – Initial Coverage, two courses**

Each course is 1000mg at 0 & 2 weeks, minimum of 24 weeks between courses

☐ **Rituximab – Renewal, two courses**

Each course is 1000mg at 0 & 2 weeks, minimum of 24 weeks between courses

Patient achieved initial response **followed by a subsequent loss of effect** ☐ Yes ☐ No

Date of last Rituximab infusion:

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 Pharmacare Drug Programs.

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**

Jan 2021/CMC

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.

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