Health PEI

SPECIAL AUTHORIZATION REQUEST

ULCERATIVE COLITIS

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

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)	PERSONAL HEALTH NUMBER (PHN)
PATIENT'S MAILING ADDRESS	

SECTION 3 – MEDICATION AND DETAIL INFORMATION

☐ **Moderate to severe active ULCERATIVE COLITIS – INITIAL APPROVAL**

☐ **Adalimumab** – Initial 8 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.

☐ **Tofactinib** – Initial 16 week approval is for a maximum dose of 10 mg twice daily.

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

PATIENT WEIGHT (kg)

MODERATE TO SEVERE ULCERATIVE COLITIS CRITERIA - CHECK/FILL OUT RELEVANT BOXES BELOW

☐ **Patient has moderate to severe active Ulcerative Colitis with a partial Mayo score >4 and a rectal bleeding subscore ≥ 2**

AND

☐ **Patient is refractory or intolerant to 5-ASA products (minimum trial of 4 weeks)**

DRUG	DOSE	DURATION OF TREATMENT
If intolerant please explain:		

AND

☐ **Patient has not responded to or intolerant to prednisone 40mg > 2 weeks or IV equivalent > 1 week**

DRUG	DOSE	DURATION OF TREATMENT
If intolerant please explain:		

OR

☐ **Patient is corticosteroid dependent**

Choose one:	Please explain:
☐ Cannot be tapered without disease recurrence **OR**	
☐ Have relapsed within 3 months of stopping treatment **OR**	
☐ Require 2 or more courses within 1 year	

SECTION 4 – CONTINUED COVERAGE (Maximum of 12 months)

☐ **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

☐ **Tofactinib** continued coverage will be limited to 10 mg twice daily

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

RENEWAL CRITERIA: ☐ Decrease in the partial Mayo score of at least 2 points from **baseline**: _____ **Most recent:**_____

AND ☐ Decrease in rectal bleeding subscore of at least 1 point from **baseline**: _____ **Most recent:**_____

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. **MARCH 2022 CMC**

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