

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 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

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:
<input type="checkbox"/> Cannot be tapered without disease recurrence OR	
<input type="checkbox"/> Have relapsed within 3 months of stopping treatment OR	
<input type="checkbox"/> 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

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
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