SPECIAL AUTHORIZATION REQUEST

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

SECTION 3 – MEDICATION AND DOSE SELECTION

☐ **Abatacept IV**	- 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**	- For adult abatacept-naive patients, a single loading dose of up to 1000mg, then 125mg sc injection given within a day, and once weekly thereafter.
☐ **Adalimumab**	- Maximum coverage is for 40mg every two weeks.
☐ **Baricitinib**	- Maximum adult coverage is for 2mg once daily.
☐ **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.
☐ **Rituximab**	- **FILL OUT SECTION 4.**
☐ **Sarilumab**	- Maximum adult dosage is 200mg every 2 weeks.
☐ **Tocilizumab IV**	- 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 800mg per infusion.
☐ **Tocilizumab SC**	- Maximum adult coverage is 162mg every other week for patients <100kg with a maximum maintenance dose escalation to 162mg weekly. For patients >100kg maximum coverage is 162mg every week with no dose escalation permitted.
☐ **Tofacitinib**	- Maximum adult coverage is for 5mg twice daily.
☐ **Tofacitinib XR**	- Maximum adult coverage is for 11mg once daily.
☐ **Upadacitinib**	- Maximum adult coverage is for 15mg once daily.

SECTION A: INITIAL 6 MONTH COVERAGE CRITERIA - CHECK AND FILL IN RELEVANT OPTIONS BELOW

☐ 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 (*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)* **AND**

☐ Patient is refractory or intolerant to methotrexate in combination with two other DMARDs (**triple therapy**) for a minimum of 12 weeks.

DMARD THERAPY USED	DOSE	DURATION & DATES	OUTCOME (SPECIFY INTOLERANCE, EFFECT)
☐ Methotrexate	_____	_____	_____
☐ Sulfasalazine	_____	_____	_____
☐ Hydroxychloroquine	_____	_____	_____
☐ Leflunomide	_____	_____	_____
☐ Other _____	_____	_____	_____

If triple DMARD therapy was not tried, describe why: _____

_____

SECTION 3 – CONTINUED

SECTION B: CONTINUED COVERAGE

Coverage will be for a maximum of 12 months, except for **biosimilars***, which will be set up for long term coverage. 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* ☐ Baricitinib ☐ Certolizumab ☐ Etanercept* ☐ Golimumab ☐ Infliximab* ☐ Sarilumab ☐ Tocilizumab ☐ Tofacitinib ☐ Upadacitinib	

SECTION 4 – ALTERNATE BIOLOGIC (RITUXIMAB)

REQUESTED COVERAGE

For the treatment of patients with rheumatoid arthritis who have a severe intolerance or other contraindication to an anti-TNF agent or failed an adequate trial of an anti-TNF agent. Rituximab will not be considered in combination with other biologic agents.

☐ Severe intolerance or other contraindication to an anti-TNF agent or failed an adequate trial of an anti-TNF agent.

NAME, DOSE & FREQUENCY OF PRIOR ANTI-TNF AGENT	**DURATION (PLEASE SPECIFY DATES)**	**SIDE EFFECTS OR CONTRAINDICATIONS (PLEASE SPECIFY)**

☐ **Rituximab – Initial Approval, two courses** (each course is 1000mg at 0 & 2 weeks, minimum of 24 weeks between courses)

☐ **Rituximab – Renewal Approval, long term**

- Patient achieved a response ☐ Yes ☐ No
- Date of last Rituximab infusion: _____

Special Authorization grants coverage to a drug that otherwise would not be eligible for coverage. Coverage is provided to patients in specific medical circumstances as defined in the PEI Pharmacare Formulary and **subject to Pharmacare Drug Program plan rules, including deductible and eligibility requirements.**

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**

Feb 2025/BB

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.

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