

## Special Authorization Request Form, for:

### **OCALIVA (*obeticholic acid*)**

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

#### **PART 1: COMPLETE THIS INFORMATION**

##### **Information about plan member**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Group number: \_\_\_\_\_ Certificate number: \_\_\_\_\_

Date of birth (DD/MM/YY): \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

#### **COORDINATION OF BENEFITS**

##### **Coverage through another health benefit plan or provincial plan**

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan?  Yes  No

**If yes, provide the following:** Name of plan member: \_\_\_\_\_

Policy/Plan number: \_\_\_\_\_ Certificate number: \_\_\_\_\_

##### **Patient assistance program**

Have you enrolled in a patient assistance program?  Yes  No

**If yes, provide your patient assistance program ID number:** \_\_\_\_\_

Provide the patient assistance program:

Contact name: \_\_\_\_\_ Phone: \_\_\_\_\_

**PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)**

**Physician Information**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

License: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

*(confirming the below information to be correct)*

**Drug being requested through Special Authorization**

New request       Request for continuation of therapy

DIN: \_\_\_\_\_ Product name: \_\_\_\_\_

Strength: \_\_\_\_\_ Dosage: \_\_\_\_\_

**Site of Administration**

Home       Private clinic       Hospital  
 Doctor's office       Cancer centre       LTC facility

**CLINICAL INFORMATION**

**Diagnosis**

Primary biliary cholangitis (PBC)

**Physician specialty**

Gastroenterologist  
 Physician specializing in treatment of primary biliary cholangitis

**CLINICAL INFORMATION (cont.)**

**Criteria for initial coverage for Primary biliary cholangitis, confirm the following:**

- Patient is 18 years of age or older; and
- Patient has diagnosis of primary biliary cholangitis; and
- Patient has tried treatment with ursodeoxycholic acid (UDCA) for at least one year and has had an inadequate response (defined as alkaline phosphatase level  $\geq 1.67$  times the ULN), and will use in combination with UDCA; or,
- As monotherapy in patients that have documented intolerance, contraindication or hypersensitivity to ursodeoxycholic acid

**NOTE:** Duration of initial approval is 6 months

**Request for continuation of therapy, confirm the following:**

- Patient has had an alkaline phosphatase (ALP) decrease of at least 15% AND ALP is  $< 1.67$  times the upper limit of normal

**NOTE:** Duration of continued approval is 1 year

**SPECIAL NOTES**

Describe any intolerances to therapy: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information that the physician believes is important to this review? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date: December 2020