

Special Authorization Request Form, for:

Rituximab Biosimilars (RUXIENCE, RIXIMYO, RIABNI, TRUXIMA)

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

- Rheumatoid Arthritis (RA)
 Granulomatosis with polyangiitis (GPA) or Microscopic polyangiitis (MPA)

Physician specialty

- Rheumatologist
 Physician with expertise in treating GPA or MPA

CLINICAL INFORMATION (cont.)

Criteria for initial coverage, confirm the following:

FOR RHEUMATOID ARTHRITIS (RA)

- Patient is 18 years of age or older; and
- Patient has severe active disease as demonstrated by ≥ 5 swollen joints; and rheumatoid factor positive; or having radiographic evidence of rheumatoid arthritis; and
- Patient has failed to respond to two disease-modifying anti-rheumatic drugs (DMARDs) or patient has a documented intolerance or contraindication to DMARDs

NOTE: Duration of initial approval is 1 year

FOR GRANULOMATOSIS WITH POLYANGIITIS (GPA) OR MICROSCOPIC POLYANGIITIS (MPA)

- Patient is 18 years of age or older; and
- Patient has a diagnosis of GPA or MPA, and disease is life- or organ threatening (details to be provided); and
- Cyclophosphamide cannot be used because:
 - the patient has failed a minimum of six IV pulses of cyclophosphamide; or
 - the patient has failed 3 months of oral cyclophosphamide therapy; or
 - the patient has a severe intolerance or an allergy to cyclophosphamide (describe); or
 - cyclophosphamide is contraindicated; or
 - the patient has received a lifetime cumulative dose of at least 25 g of cyclophosphamide; or
 - the patient wishes to preserve ovarian/testicular function for fertility; and
- rituximab* is used in combination with systemic corticosteroids

NOTE: Duration of initial approval is one course of therapy (4 weeks)

Request for continuation of therapy, confirm the following:

FOR RHEUMATOID ARTHRITIS (RA)

- Patient demonstrates continued therapeutic benefit, such as objective evidence of at least a 20% reduction in swollen joint count and a minimum improvement in 2 swollen joints over the previous year

NOTE: Duration of continued approval is 1 year

FOR GRANULOMATOSIS WITH POLYANGIITIS (GPA) OR MICROSCOPIC POLYANGIITIS (MPA)

- Patient meets same criteria for initial coverage as outlined above
- Requests for retreatment must be made at least 6 months after initial cycle of *rituximab*

NOTE: Duration of continued approval is one course of therapy (4 weekly doses)

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? _____
