Exception Drug Status (EDS) Request

Biologics for Ankylosing Spondylitis (AS)

- Requests MUST be submitted by prescribers (or their clinics) or pharmacies.
- Requests from patients or Patient Support Programs (PSPs) will NOT be accepted.
- INCOMPLETE FORMS may result in a delay in processing the request. Please ensure each section is completed.

Ministry of Health
Drug Plan and Extended Benefits
3475 Albert Street
Regina SK S4S 6X6
Phone: 1-800-667-2549
Fax: 306-798-1089
E-mail: DPEB@health.gov.sk.ca

Section 1 - Requester Information

Name (first & last): _____ Address (or clinic/pharmacy name): _____

Telephone Number: _____ Fax Number: _____

Requester Type **(required)**:

☐ Physician ☐ Pharmacist ☐ Nurse ☐ Other Health Professional (please specify): _____

Prescriber Name (if different than requester) and Telephone Number: _____

Section 2 - Patient Information

Name (first & last): _____

Health Services Number (HSN): _____ Date of Birth: _____ (dd/mm/yyyy)

Section 3 - Drug Information

- Requests for coverage for this indication must be made by a rheumatologist.
- Patients are limited to receiving one biologic agent at a time regardless of the indication for which it is being prescribed.

Please provide the following information:

1. Medication Requested: _____
2. Dose: _____

NOTES:
BASDAI = Bath Ankylosing Spondylitis Disease Activity Index
VAS = Visual Analogue Scale

Section 4 - Initial Request for EDS (complete for new starts and/or patient's first EDS request)

1. Has the patient already been treated conventionally with two or more non-steroidal anti-inflammatory drugs (NSAIDs) taken sequentially at maximum tolerated or recommended doses for four weeks without symptom control? ☐ Yes ☐ No
2. Please provide the patient's baseline scores:

   BASDAI: _____ Date: _____ (dd/mm/yyyy)

   VAS #1: _____ Date: _____ (dd/mm/yyyy)

   VAS #2: _____ Date: _____ (dd/mm/yyyy)

NOTE: for coverage consideration, the individual must satisfy the New York diagnostic criteria of BASDAI ≥4 AND VAS ≥4cm on two occasions at least 12 weeks apart without any change of treatment.

Initial approval duration: 12-weeks (or 16 weeks for Cosentyx (secukinumab))

Section 5 - Second Application (First Renewal)

1. Has the patient had an adequate response to treatment assessed at 12 weeks (or 16 weeks for Cosentyx (secukinumab))? ☐ Yes ☐ No

   NOTE: an adequate response is defined by at least a 50% reduction in pre-treatment baseline BASDAI (or by ≥2 units) AND a reduction of ≥2cm in spinal pain VAS.

2. Please provide the patient's current scores:

   BASDAI: _____ Date: _____ (dd/mm/yyyy)

   VAS #1: _____ Date: _____ (dd/mm/yyyy)

Renewal approval duration: 1 year

Section 6 - Subsequent Annual Renewal

1. Has the patient's BASDAI score remained within 2 units of the second application (first renewal) AND remained at least 2 units less than the initial application's BASDAI score? ☐ Yes ☐ No

2. Please provide the patient's current score:

   BASDAI: _____ Date: _____ (dd/mm/yyyy)

Renewal approval duration: 1 year

Section 7 - Additional Information (if applicable)

Requester Signature: _____ Date: _____ (dd/mm/yyyy)