Request for Biologics for Juvenile Spondyloarthritis or Enthesitis Related Arthritis Exceptional Access Program (EAP)

Not for Other Inflammatory Disorders

ORA Ontario Rheumatology Association

To avoid delays, please ensure that all appropriate information for each section is provided.

Section 1 - Physician Information

First Name	Initial	Last Name

Street #	Street Name

City	Postal Code

Fax	Telephone (Back Line)

Section 2 - Patient Information

First Name	Initial	Last Name

Ontario Health Insurance Number	

Gender ☐ Male ☐ Female	Current Weight (kg)

Date of Birth (DD/MM/YYYY)

Request Type ☐ New Request (complete all sections) ☐ Renewal Request (complete sections 3, 4B, 7)

Is the patient currently taking the drug requested below? ☐ Yes - Start Date (DD/MM/YYYY): ☐ No

EAP # **OR** ☐ TFA Mechanism Previously Used

Section 3 – Drug, Dose and Regimen Requested

☐ **etanercept** (Enbrel®) 0.4mg/kg (max 25mg) twice weekly or 0.8mg/kg (max 50mg) once weekly

☐ **infliximab** (Remicade®) 5 mg/kg/dose IV at 0, 2, 6 weeks followed by maintenance therapy of 5 mg/kg/dose IV every 6-8 weeks

Dosage

Dosing Frequency

Section 4A: Indication of Active Disease

Diagnosis of Active JSpA/ERA

1. Axial JSpA

☐ Age of onset ≤ 16

AND

☐ Low back pain and stiffness for > 3 months that improves with exercise and not relieved by rest

AND

☐ Failure of or intolerance to at least 2 NSAIDs tried for at least 4 weeks each

AND

☐ BASDAI score ≥ 4 after at least 4 weeks of NSAID therapy

AND

☐ Radiographic report confirmed by:

- ☐ X-ray/CT of SI Joint featuring: ☐ Erosions ☐ Fusion
- ☐ MRI of SI Joint featuring: ☐ Edema ☐ Inflammation ☐ Erosions

OR 2. Peripheral JSpA

☐ Age of onset ≤ 16

AND

☐ ≥ 3 swollen joints

AND

☐ ≥ 5 active joints

AND

☐ ≥ 2 enthesitis sites

AND

☐ Failure or intolerance to at least 2 NSAIDs tried for at least 4 weeks each

AND

☐ Failure or intolerance to at least one DMARD (sulfasalazine 50 mg/kg/day or methotrexate 15 mg/m^2) for at least 3 months

Section 4B: Response to Treatment

Renewal requests should demonstrate for AXIAL: 50% reduction or ≥2 absolute point reduction in BASDAI score. For PERIPHERAL: 20% decrease or at least 2 swollen joints improvement, and fewer enthesitis sites. For renewals beyond the second year, objective evidence of preservation of treatment effect must be provided.

Clinical Marker	Prior-to Requested Biologic	Renewal 1	Renewal 2	Renewal 3
Peripheral Swollen Joint Count				
BASDAI score				
Date (DD/MM/YYYY)				

Section 5 - Previous NSAIDs used

Provide details of use and response to NSAIDs used in the past

NAME OF NSAID	DOSING REGIMEN	START DATE (DD/MM/YYYY)	END DATE (DD/MM/YYYY)	REASON FOR DISCONTINUATION Details of intolerance, contraindication, failure at maximum dose or inadequate response must be provided

Section 6 - DMARD trial if predominantly peripheral arthritis present or N/A ☐

DMARD	DOSING REGIMEN	START DATE (DD/MM/YYYY)	END DATE (DD/MM/YYYY)	RESPONSE

Section 7 - List all current medications relevant to rheumatic diagnosis, including dosage and indication

Physician Signature (Mandatory)	CPSO Number	Date (DD/MM/YYYY)

Please fax the completed form and/or any additional relevant information to **416-327-7526** or toll free **1-866-811-9908**; or send to the Drug Programs Branch, 3rd Floor, 5700 Yonge Street, North York, Ontario, M2M 4K5. **For any patient under 25 please fax to OHIP + at 1-844-227-6590**. For copies of EAP forms, please visit: **http://ontariorheum.ca/drug-forms-and-codes/eap-forms**

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