Request for Biologics for Polyarticular-Course Juvenile Idiopathic Arthritis Exceptional Access Program (EAP)

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)

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 *(attach additional sheets if more space is required)*

☐	**abatacept** (Orencia™)*	250 mg/15 mL vial. 10 mg/kg/dose IV at 0, 2, 4 weeks then every 4 weeks (not to exceed 1000 mg per dose)
☐	**adalimumab** (Humira®)	24 mg/m² (max 40 mg) SC every 2 weeks; or < 30 kg 20 mg SC every 2 weeks, ≥ 30 kg 40 mg SC every 2 weeks
☐	**etanercept** (Enbrel®)	25 mg/vial, 50 mg prefilled syringe; 0.8 mg/kg/week. Dose not to exceed 50 mg subcutaneously each week

Initial requests for Enbrel will only be accepted for patients **under** 63kg. Note that Erelzi is considered for PJIA for patients **over** 63kg meeting LU criteria (LU code 514).

☐	**infliximab** (Remicade®)*	Up to 6 mg/kg/dose IV at 0, 2, 6 weeks followed by maintenance therapy of up to 6 mg/kg/dose IV every 8 weeks
☐	**tocilizumab** (Actemra®)	80 mg/4 mL vial, 200 mg/10 mL vial, 400 mg/20 mL vial; 10 mg/kg IV every 4 weeks if < 30 kg, 8 mg/kg IV every 4 weeks if ≥ 30 kg

Dosage

Dosing Frequency

*Failure of (trial of at least 3 months), intolerance of, or contraindication to etanercept OR adalimumab OR tocilizumab must be documented.

Section 4A
Indication of Active Disease

Diagnosis of active JIA:

☐ ≥ 3 Swollen Joints

AND

☐ ≥ 5 Active Joints

Section 4B
Response to Treatment

Initial renewal requests should demonstrate a 20% reduction in swollen joint count and a minimum of improvement in 2 swollen joints over the previous year. For renewals beyond the second year, objective evidence of the preservation of treatment effect must be provided.

Clinical Marker	Prior-to Requested Biologic	Renewal 1	Renewal 2	Renewal 3	Renewal 4
Swollen Joint Count					
Active Joint Count					
Date (DD/MM/YYYY)					

Section 5 - Previous/Current Disease Modifying Anti-Rheumatic Drug (DMARD) or Biologic Therapy

Provide details of use of subcutaneous methotrexate (15mg/m² per week) for at least 3 months. If unable to tolerate or has a contraindication to subcutaneous methorexate, detail the intolerance or contraindication. For abatacept or infliximab requests, provide details of prior etanercept or adalimumab or tocilizumab failure and/or intolerance or contraindication.

Name of Drug	Dosing Regimen and Route (e.g. po/sc/IV)	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Reason For Discontinuation Details of intolerance, contraindication, or failure at maximum dose must be provided
methotrexate				

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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