Request for Tocilizumab (Actemra) for Giant Cell Arteritis (GCA) Exceptional Access Program (EAP)

Not for Pediatric Cases

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

Section 2 – Patient Information

First Name	Initial	Last Name

Ontario Health Insurance Number

Gender	Date of Birth (DD/MM/YYYY)
◯ Male ◯ Female	

Request Type

☐ New Request (complete all sections)

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

☐ Renewal Request (Complete all but section 5) Prior EAP Request #

Section 3 – Drug, Dose and Regimen Requested *(attach additional sheets if more space is required)*

◯ **tocilizumab (Actemra)** 162 mg sc once a week in combination with a tapering course of corticosteroid

◯ **tocilizumab (Actemra)** 162 mg sc once every other week in combination with a tapering course of corticosteroid

Section 4 – Clinical Information *(attach additional sheets if more space is required)*

Funding for tocilizumab (Actemra) will be considered for the treatment of new onset or relapsed Giant Cell Arteritis (GCA) through the Exceptional Access Program (EAP) in adult patients meeting all the following criteria:

Symptoms of GCA

Please provide a description of the patient's symptoms of GCA at the time of diagnosis. You may attach a copy of consult notes or clinic notes.

Diagnosis of GCA

☐ Temporal artery biopsy

◯ Biopsy positive ◯ Results not available

◯ Biopsy negative

Please provide a copy of the report including the date of the result

☐ Imaging tests[1]

◯ Positron emission scanning ◯ Computed tomography angiography

◯ Ultrasound ◯ Magnetic resonance angiography

Please provide a description of the patient's symptoms of GCA at the time of diagnosis. You may attach a copy of consult notes or clinic notes.

If patient does not have a Positive Temporal Artery Biopsy result please include an imaging test and CRP and/or ESR levels to support the diagnosis of GCA (Request may be reviewed by an external medical expert).

CRP	Date of CRP (DD/MM/YYYY)	ESR	Date of ESR (DD/MM/YYYY)

Tociluzumab (Actemra) is initiated as combination therapy with 20 mg to 60 mg of prednisone (or an equivalent corticosteroid) with subsequent corticosteroid tapering as symptoms stabilize

NAME OF DRUG	DOSING REGIMEN	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
Prednisone				

☐ **Prescribed by a rheumatologist or a prescriber with expertise in the diagnosis and management of GCA.**

[1]Where these tests are not available or where a result may be deemed unreliable (e.g. a negative biopsy in a patient on corticosteroids), provide C-reactive protein (CRP) and/or Erythrocyte Sedimentation Rate (ESR) results with your request.

Section 5 – Renewal Information

Tociluzumab (Actemra) for GCA is funded for 12 months total. If your patient has unique circumstances which warrant renewal of funding, attach additional clinical details and include responses to the questions in this section.

Describe relevant symptom response experienced to Tocilizumab (Actemra) treatment for GCA:

Has there been any relapses/flares during treatment?
◯ Yes Approx. # ◯ No

Has there been hospitalizations from GCA during the treatment period?
◯ Yes # in past year ◯ No

Has the patient been able to taper the dose of corticosteroid following disease stabilization?
◯ Yes ◯ No

Has the patient experienced any toxicities to Tocilizumab (Actemra)? ◯ Yes ◯ No

CRP	Date of CRP (DD/MM/YYYY)	ESR	Date of ESR (DD/MM/YYYY)

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**