Request for Biologics for Systemic 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 ☐ Renewal Request (complete section 5)

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)*

		Dosage	Dosing Frequency
☐ **tocilizumab** (Actemra®) 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL	< 30 kg: 12 mg/kg IV every 2 weeks, ≥ 30 kg: 8 mg/kg IV every 2 weeks. Recommended maximum adult dose is 800 mg.		
☐ **anakinra** (Kineret®) 100 mg/0.67 mL prefilled syringe.	1 to 2 mg/kg subcutaneous once daily.		

Section 4 – Clinical Information

1. What is the patient's diagnosis for which the biologic is being requested for funding consideration?

☐ Systemic Juvenile Idiopathic Arthritis ☐ Other (Specify):

Has the patient experienced fever greater than 38°C for at least 2 weeks? ☐ Yes ☐ No

Has the patient had arthritis of at least one joint? ☐ Yes ☐ No

2. Which of the following systemic features has this patient experienced? (Check all that apply)

☐ Rash of systemic JIA ☐ Serositis (e.g. pericarditis, pleurtis or peritonitis) ☐ Lymphadenopathy (e.g. cervical, axillary, inguinal)

☐ Hepatomegaly ☐ Splenomegaly ☐ Macrophage activation syndrome

3. Have other potential etiologies been ruled out? (e.g. malignancies, infections, inflammatory or connective tissue diseases) ☐ Yes ☐ No

4. Specify the age of disease onset for this patient: Years

5. Name of Corticosteroid	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Response to therapy (Check all that apply)
			☐ Unresponsive and/or refractory to therapy ☐ Experienced a systemic reaction (e.g. fever, rash of sJIA, serositis, lymphadenopathy, hepatomegaly, or splenomegaly) while on tapering doses ☐ Patient experienced an adverse drug reaction to the corticosteroid

6. If a corticosteroid has not been used please specify the reason(s).

☐ Contraindication Specify: ☐ Other Specify:

7. List other DMARDs or biologic therapies that have been tried.

Drug (include dose used)	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Response to therapy (Include reasons for discontinuation)

Section 5 – Renewal Information

Renewals will be considered for patients demonstrating at least a 50% reduction in corticosteroid dose (unless contraindicated, not tolerated, unresponsive or refractory at the time of initial request) and no evidence of active systemic disease. For renewals beyond the second year, objective evidence of preservation of treatment effect must be provided.

☐ First Renewal ☐ Second Renewal and beyond	Current Corticosteroid dose If dose not reduced by ≥ 50% from prior to biologic, provide reasons	Is the patient experiencing any active signs or symptoms of systemic disease? (e.g. serositis, lymphadenopathy, hepatomegaly, splenomegaly)? ☐ No ☐ Yes Specify: For 2nd or later renewals, describe objective evidence of preservation of treatment effect in the space below:

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 + 1-844-227-6590**. For copies of EAP forms, please visit: **http://ontariorheum.ca/drug-forms-and-codes/eap-forms**