Request for Biologics for Psoriatic Arthritis (PsA)
Exceptional Access Program (EAP)

Not for Other Inflammatory Disorders

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

☐ Initial Request (Complete all sections) ☐ Renewal Request (Complete sections 3, 4B)

Section 3 - Drug, Dose and Regimen Requested

☐ **adalimumab** (Humira®)	40 mg SC every two weeks	
☐ **etanercept** (Enbrel®)	25 mg SC twice weekly or 50 mg SC once weekly	
☐ **golimumab** (Simponi®)	50 mg SC once monthly	
☐ **infliximab** (Remicade®)*	maintenance therapy of 3-5 mg/kg/dose IV every 8 weeks	

Dosage

Dosing Frequency

***Only renewal requests of existing EAP approvals for infliximab may be grandfathered and screened according to established renewal criteria. New EAP requests for PsA will not be considered.**

Section 4A
Indication of Active Disease

Diagnosis of active PsA

☐ ≥ 5 swollen joints

AND

☐ Radiographic evidence of PsA

if < 5 swollen joints, provide location of swollen joints

Section 4B
Response to Treatment

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	Pre-biologic	Renewal 1	Renewal 2	Renewal 3	Renewal 4
Swollen Joint Count					
Date (DD/MM/YYYY)					

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

Provide details of use and response to treatment with Methotrexate (20 mg/wk) for at least 3 months and either leflunomide (20 mg/day) **OR** sulfasalazine (1gm twice daily) for at least 3 months. If patient has documented contraindications or intolerances to methotrexate, then only one of leflunomide or sulfasalazine for at least 3 months is required. Details of contraindications and intolerances must be provided.

NAME OF DMARD	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
methotrexate				
leflunomide				
sulfasalazine				

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 copies of EAP forms, please visit: http://www.health.gov.on.ca/english/public/forms/form_menus/odb_fm.html or call 416-314-9738 or 1-866-811-9893.