

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
ABILIFY MAINTENA	Aripiprazole	PSYCHIATRIC DISORDERS	PharmaCare Special Authority Approval Required	NA
ACTEMRA	Tocilizumab	JUVENILE IDIOPATHIC ARTHRITIS, RHEUMATOID ARTHRITIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
ADCIRCA (including generics)	Tocilizumab	PULMONARY ARTERIAL HYPERTENSION	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
ADEMPAS	Riociguat	1) INOPERABLE THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) 2) PERSISTENT OR RECURRENT CTEPH AFTER SURGICAL TREATMENT 3) PULMONARY ARTERIAL HYPERTENSION	ClaimSecure Special Authorization Required - Confirmed diagnosis of CTEPH in adult patients with WHO Functional Class II or III pulmonary hypertension with: --> Inoperable disease OR --> Persistent or recurrent disease post-surgery - For the treatment of adult patients with WHO FC II-III pulmonary arterial hypertension who have tried and failed or cannot tolerate Revatio or Adcirca (minimum 3 months trial) AND Tracleer (bosentan)	NA
ADLYXINE	Lixisenatide	TYPE II DIABETES	ClaimSecure Special Authorization Required 1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea AND 2) Patient has tried and failed or cannot tolerate a DPP-4 inhibitor, SGLT2 inhibitor or TZD	NA
ADVAIR	Fluticasone / salmeterol	Asthma/COPD	ClaimSecure Special Authorization Required 1) Tried and failed inhaled corticosteroid and short-acting beta agonist, or 2) Patient has PharmaCare Special Authority approval for the requested drug	Respirologist or Allergist
AIMOVIG	Erenumab	MIGRAINES	ClaimSecure Special Authorization Required Initial Criteria (6 months): - For the prevention of migraine in adults (18+ years old) with at least 8 migraines per month, who have tried and failed, are intolerant or have a contraindication to at least 2 migraine prevention therapies (ie: tricyclic analgesics, antiepileptic drugs, beta blockers). Must indicate number of migraine days per month Renewal Criteria (1 year): - Clinical benefit demonstrated by: - ≥ 30% reduction in number of migraine days per month OR - Reduction in use of acute migraine medications	NA
APTIOM	Eslicarbazepine	PARTIAL ONSET SEIZURES	PharmaCare Special Authority Approval Required	NA
ARANESP	Darbepoetin Alfa	1) ANEMIA WITH CHEMOTHERAPY 2) CHRONIC RENAL FAILURE	ClaimSecure Special Authorization Required For patients with: -chronic renal failure -anemia secondary to chemotherapy	NA

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ARAVA	Leflunomide	RHEUMATOID ARTHRITIS	PharmaCare Special Authority Approval Required	NA
AUBAGIO	Teriflunomide	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
AVONEX	Interferon beta-1a	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
BANZEL	Rufinamide	LENNOX-GASTAUT SYNDROME	PharmaCare Special Authority Approval Required	NA
BARACLUDE (including generics)	Entecavir	CHRONIC HEPATITIS B	PharmaCare Special Authority Approval Required	NA
BENLYSTA	Belimumab	SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)	ClaimSecure Special Authorization Required - For adult patients (≥ 18 years old) with moderate-severe SLE being treated by a rheumatologist - Patient must be autoantibody positive (within last 3 months) i.e. ANA or dsDNA positive with SELENA-SLEDAI score ≥ 6 who have tried and failed or are intolerant to corticosteroid and hydroxychloroquine - Renewal based on achieving/maintain a SELENA-SLEDAI reduction of 4 points or more	NA

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BETASERON	Interferon beta-1b	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
BOTOX	OnabotulinumtoxinA	BOTOX/XEOMIN	<p>ClaimSecure Special Authorization Required</p> <p>For patients with of one of the following conditions:</p> <ul style="list-style-type: none"> <li>-Treatment of Blepharospasm in patient 12 years of age or older</li> <li>-Treatment of Strabismus in patient 12 years of age or older</li> <li>-Reduce symptoms and signs of Cervical Dystonia (spasmodic torticollis) in adult</li> <li>-Management of Focal Spasticity in adult</li> <li>-Treatment of Equinus Foot Deformity in patient 2 years of age or older</li> <li>-Treatment of Primary Hyperhidrosis of Axillae in adult</li> <li>-Prophylaxis of headaches in adult with Chronic Migraines</li> <li>-Treatment of Neurogenic Detrusor Overactivity associated with neurological condition in adult (urinary incontinence)</li> <li>-Treatment of Overactive Bladder in adult with inadequate response or intolerance of anticholinergic medication</li> </ul> <p>OR</p> <p>Patient has PharmaCare Special Authority approval for the requested drug</p> <p>Approval for 2 years</p>	Physician has Collaborative Prescribing Agreement with BC PharmaCare
BREO ELLIPTA	Fluticasone / Vilanterol	Asthma/COPD	<p>ClaimSecure Special Authorization Required</p> <ol style="list-style-type: none"> <li>1) Tried and failed inhaled corticosteroid and short-acting beta agonist, or</li> <li>2) Patient has PharmaCare Special Authority approval for the requested drug</li> </ol>	Respirologist or Allergist
BRENZYS	Etanercept	Immune-mediated inflammatory disorder	PharmaCare Special Authority Approval Required	Pediatric rheumatologists for pediatric patients diagnosed with rheumatoid arthritis.
BYDUREON	Exenatide extended release	TYPE II DIABETES	<p>ClaimSecure Special Authorization Required</p> <ol style="list-style-type: none"> <li>1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea AND</li> <li>2) Patient has tried and failed or cannot tolerate a DPP-4 inhibitor, SGLT2 inhibitor or TZD</li> </ol>	NA

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BYETTA	Exenatide	TYPE II DIABETES	ClaimSecure Special Authorization Required 1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea AND 2) Patient has tried and failed or cannot tolerate a DPP-4 inhibitor, SGLT2 inhibitor or TZD	NA
CARIPUL	Epoprostenol	PULMONARY ARTERIAL HYPERTENSION	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
CAYSTON	Aztreonam	CYSTIC FIBROSIS	PharmaCare Special Authority Approval Required	NA

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CIMZIA	Certolizumab	ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS, RHEUMATOID ARTHRITIS	PharmaCare Special Authority Approval Required	NA
CINQAIR	Reslizumab	SEVERE PERSISTENT ASTHMA	<p>ClaimSecure Special Authorization Required</p> <p><u>Initial Criteria:</u></p> <p>1) 18 years of age or older and                      2) Has been a non-smoker for at least the past 6 months and                      2) Trial and failure to medium to high dose inhaled corticosteroids and other asthma agent such as long acting beta-agonist or leukotriene receptor antagonists and                      3) Experienced at least 1 or more exacerbation in the previous 12 months and                      4) Blood eosinophil count <math>\geq 400</math> cells /<math>\mu</math>L at initiation of therapy</p> <p><u>Renewal Criteria:</u></p> <p>Patient has responded to therapy as evidenced by:</p> <p>1) Decrease in asthma exacerbations or                      2) Decrease in rescue medications or                      3) Improvement of symptoms or                      4) Continue to maintain non-smoking status</p> <p>1 year approval</p>	NA
COMTAN	Entacapone	PARKINSON'S DISEASE	PharmaCare Special Authority Approval Required	
COPAXONE	Glatiramer Acetate	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
COSENTYX	Secukinumab	ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, PSORIATIC ARTHRITIS	PharmaCare Special Authority Approval Required	NA
DAKLINZA	Daclatasvir	CHRONIC HEPATITIS C	Patient has PharmaCare Special Authority approval for the requested drug	NA
DEXILANT	Dexlansoprazole	GASTROINTESTINAL/ULCER THERAPY	<p>ClaimSecure Special Authorization Required</p> <p>For the treatment of patient:</p> <p>- with duodenal ulcer, reflux esophagitis, gastric ulcer or erosive esophagitis and                      - has tried and failed either omeprazole, rabeprazole, pantoprazole, lansoprazole, esomeprazole or has a medical reason for not trying the listed proton pump inhibitors</p> <p>Approval duration: 6 months</p>	Gastroenterologist

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DIACOMIT	Stiripentol	EPILEPSY	ClaimSecure Special Authorization Required 1) Patients 3 years of age or older with refractory SMEI or Dravet Syndrome AND 2) Must be used with clobazam and valproate after failure with clobazam and valproate alone OR Patient has PharmaCare Special Authority approval for the requested drug	NA
DIFICID	Fidaxomicin	CLOSTRIDIUM DIFFICILE	PharmaCare Special Authority Approval Required	NA
DUODOPA	Levodopa/carbidopa intestinal gel	PARKINSON'S DISEASE	ClaimSecure Special Authorization Required 1) For individuals with advanced Parkinson's disease and who have tried and failed other oral therapies for control of severe, disabling motor fluctuations 2) Individuals are being screened and managed by specialists and at appropriate centers where the individuals have responded to the drug during the test phase	NA
DUPIXENT	Dupilumab	SEVERE ATOPIC DERMATITIS	ClaimSecure Special Authorization Required *Initial Approval: 6 months duration - For the treatment of adult patients (18+) with confirmed severe atopic dermatitis: --> Severity defined as meeting all 3 conditions below: 1) IGA of 3 or more 2) BSA of at least 30% or EASI ≥21 3) DLQI ≥ 10 or severe disruption in sleep; --> Tried and failed one product from each class below: 1) High potency topical steroids 2) Protopic or Elidel 3) Oral corticosteroid therapy and/or immunosuppressants (cyclosporine, azathioprine, methotrexate, etc) *Renewal criteria: 1 year duration - IGA of 0 or 1 or 50% improvement, AND improvement of EASI of at least 75% of initial score AND 5 point improvement in DLQI or improvement in sleep	NA

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DURAGESIC (including generics)	Fentanyl	CHRONIC PAIN	PharmaCare Special Authority Approval Required	Oncologist (medical), Oncologist (radiation), Haematologist
DYSPORT	AbobotulinumtoxinA	CERVICAL DYSTONIA OR FOCAL SPASTICITY	ClaimSecure Special Authorization Required For adults with one of the following conditions: -Reduce symptoms and signs of Cervical Dystonia (spasmodic torticollis) -Symptomatic treatment of Focal Spasticity affecting the upper limbs in adults OR Patient has PharmaCare Special Authority approval for the requested drug  Approval for 2 years	NA
ELIQUIS	Apixaban	ORAL ANTICOAGULANTS	ClaimSecure Special Authorization Required 1)For the treatment of patients with non-valvular atrial fibrillation, treatment or prevention of deep vein thrombosis (DVT) or pulmonary embolism (PE) and 2) Patient does not have severe renal impairment and 3) Meets one of the following criteria: - Patient has PharmaCare Special Authority approval for the requested drug (attach approval form if applicable) or - Patient has tried warfarin for at least two months or - Patient is unsuitable for warfarin because of liver damage, hypersensitivity to warfarin, inability to monitor INR, embolic event with warfarin, inability to maintain a therapeutic INR, or other contraindication to warfarin	NA
ENBREL	Etanercept	Immune-mediated inflammatory disorder	PharmaCare Special Authority Approval Required	Pediatric rheumatologists for pediatric patients diagnosed with rheumatoid arthritis
ENTRESTO	Sacubitril / Valsartan	HEART FAILURE	Patient has PharmaCare Special Authority approval for the requested drug	NA
ENTYVIO	Vedolizumab	CROHN'S DISEASE, ULCERATIVE COLITIS	PharmaCare Special Authority Approval Required	NA
EPCLUSA	Sofosbuvir/ Velpatasvir	CHRONIC HEPATITIS C	PharmaCare Special Authority Approval Required	NA
EPREX	Erythropoietin	ANEMIA	ClaimSecure Special Authorization Required For patients: -with chronic renal failure undergoing dialysis treatment -with anemia secondary to chemotherapy -requiring a transfusion from anemia related to therapy with zidovudine in HIV-infected patients	NA

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ERELZI	Etanercept	Immune-mediated inflammatory disorder	Patient has PharmaCare Special Authority approval for the requested drug	Pediatric rheumatologists for pediatric patients diagnosed with rheumatoid arthritis.
ESBRIET	Pirfenidone	IDIOPATHIC PULMONARY FIBROSIS	Patient has PharmaCare Special Authority approval for the requested drug	NA
EUCRISA	Crisaborole	ATOPIC DERMATITIS	ClaimSecure Special Authorization Required - For patients with atopic dermatitis (eczema) who have failed or are intolerant to treatments with topical corticosteroid therapy	NA
EXJADE (including generics)	Deferasirox	IRON OVERLOAD	PharmaCare Special Authority Approval Required	NA



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EXTAVIA	Interferon beta-1b	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
EYLEA	Aflibercept	AMD	ClaimSecure Special Authorization Required For patients with: -Neovascular (wet) age-related macular degeneration (AMD) OR -Visual impairment due to Diabetic macular edema OR -Visual impairment due to macular edema secondary to Central or Branch Retinal Vein Occlusion OR -Myopic Choroidal Neovascularization (myopic CNV)	NA
FAMPYRA	Fampridine	MULTIPLE SCLEROSIS	ClaimSecure Special Authorization Required <u>Initial Criteria:</u> - For patients diagnosed with Multiple Sclerosis with walking disability (EDSS 3.5 – 7) - An initial 6 weeks of Fampyra will be approved  <u>Renewal Criteria:</u> - Demonstrates a noted improvement in walking speed from baseline based on one of the following clinical tools (e.g. T25FW, Timed Up and Go, MSWS012, Two Minute Walk)	NA
FASENRA	Benralizumab	SEVERE PERSISTENT ASTHMA	ClaimSecure Special Authorization Required <u>Initial Criteria:</u> 1) 18 years of age or older and 2) Has been a non-smoker for at least the past 6 months and 2) Trial and failure to high dose inhaled corticosteroids and other asthma agent such as long acting beta-agonist or leukotriene receptor antagonists and 3) Blood eosinophil count $\geq 300$ cells / $\mu$ L AND experienced 2 or more exacerbations in the past 12 months OR patient has blood eosinophil count $\geq 150$ cells / $\mu$ L AND is treated chronically with oral corticosteroids <u>Renewal Criteria:</u> Patient has responded to therapy as evidenced by: 1) Decrease in asthma exacerbations or 2) Decrease in rescue medications or 3) Improvement of symptoms or 4) Continue to maintain non-smoking status  1 year approval	NA
FERRIPROX	Deferiprone	IRON OVERLOAD	PharmaCare Special Authority Approval Required	NA

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FLOLAN	Epoprostenol	PULMONARY ARTERIAL HYPERTENSION	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
FORTEO	Teriparatide	OSTEOPOROSIS	ClaimSecure Special Authorization Required For the treatment of patients diagnosed with osteoporosis with: - severe osteoporosis with high risk of fracture (as per FRAX or CAROC tool) - intolerant or tried and failed bisphosphonate or denosumab therapy - documentation if patient has tried Forteo previously	NA
FORXIGA	Dapagliflozin	TYPE II DIABETES	ClaimSecure Special Authorization Required - Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea	NA

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FRAGMIN	Dalteparin	THROMBOPROPHYLAXIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
FREESTYLE LIBRE	(Sensor only)	DIABETES MONITORING	ClaimSecure Special Authorization Required - For blood glucose monitoring in adult diabetic patients (18+) treated with insulin - Approval Maximum 26 sensors per calendar year	NA
FYCOMPA	Perampanel	PARTIAL ONSET SEIZURES	PharmaCare Special Authority Approval Required	NA
GENOTROPIN	Somatropin	GROWTH HORMONE DEFICIENCY	PharmaCare Special Authority Approval Required	NA
GILENYA	Fingolimod	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	NA
GLATECT	Glatiramer	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	NA
GLYXAMBI	Empagliflozin/ Linagliptin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea	NA
GRASTOFIL	Filgrastim	NEUTROPENIA	PharmaCare Special Authority Approval Required	NA
HARVONI	Ledipasvir/ Sofosbuvir	CHRONIC HEPATITIS C	PharmaCare Special Authority Approval Required	NA
HEPSERA (including generics)	Adefovir	CHRONIC HEPATITIS B	PharmaCare Special Authority Approval Required	NA
HEPTOVIR	Lamivudine	CHRONIC HEPATITIS B	ClaimSecure Special Authorization Required - For treatment of chronic hepatitis B OR Patient has PharmaCare Special Authority approval for the requested drug	NA
HUMATROPE	Somatropin	GROWTH HORMONE DEFICIENCY	PharmaCare Special Authority Approval Required	NA
HUMIRA	Adalimumab	IMMUNE-MEDIATED INFLAMMATORY DISORDERS	PharmaCare Special Authority Approval Required	NA
HYDROMORPH CONTIN	Hydromorphone Controlled Release	CHRONIC PAIN	PharmaCare Special Authority Approval Required	Oncologist (medical), Oncologist (radiation), Haematologist
IBAVYR	Ribavirin	CHRONIC HEPATITIS C	PharmaCare Special Authority Approval Required	NA
IMITREX	Sumatriptan	MIGRAINES	PharmaCare Special Authority Approval Required	Neurology
INFLECTRA	Infliximab	IMMUNE-MEDIATED INFLAMMATORY DISORDERS	PharmaCare Special Authority Approval Required	Pediatric rheumatologists have an exemption
INTRON A	Interferon alfa-2b	CHRONIC HEPATITIS B	PharmaCare Special Authority Approval Required	NA
INVEGA SUSTENNA	Paliperidone	SCHIZOPHRENIA	PharmaCare Special Authority Approval Required	NA
INVEGA TRINZA	Paliperidone	SCHIZOPHRENIA	PharmaCare Special Authority Approval Required	

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INVOKAMET	Canagliflozin / Metformin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea	NA
INVOKANA	Canagliflozin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea	NA

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JADENU	Deferasirox	IRON OVERLOAD	PharmaCare Special Authority Approval Required	NA
JAKAVI	Ruxolitinib	SPLENOMEGALY	ClaimSecure Special Authorization Required For the treatment of splenomegaly and/or its associated symptoms (weight loss, fever, night sweats, fatigue, bone pain, pruritus, peripheral edema) in adult patients diagnosed with: - Primary myelofibrosis (also known as chronic idiopathic myelofibrosis) - Post-polycythemia vera myelofibrosis - Post-essential thrombocythemia myelofibrosis	NA
JANUMET/JANUMET XR	Sitagliptin / Metformin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea	NA
JANUVIA	Sitagliptin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea	NA
JARDIANCE	Empaglifozin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea	NA
JENTADUETO	Linagliptin / Metformin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea OR Patient has PharmaCare Special Authority approval for the requested drug	NA
JETREA	Ocriplasmin	VITREOMACULAR ADHESION	PharmaCare Special Authority Approval Required	NA

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JINARC	Tolvaptan	ADPKD	<p>ClaimSecure Special Authorization Required</p> <p>Initial Criteria:</p> <ul style="list-style-type: none"> <li>- Confirmed diagnoses of rapidly progressive ADPKD and must have:</li> <li>a) Total kidney volume <math>\geq</math> 750ml AND</li> <li>b) CrCl <math>\geq</math> 60ml/min</li> </ul> <p>- Proof of enrollment in the Support Program</p> <p>Renewal Criteria:</p> <ul style="list-style-type: none"> <li>- Proof of continued enrollment in the patient support program</li> <li>- Laboratory results demonstrating normal liver (ALT and AST) function</li> <li>- Proof of beneficial effect demonstrated by:</li> <li>a) Urine osmolality of less than 300 mOsm/kg</li> </ul>	NA
JURNISTA	Hydromorphone Extended Release	CHRONIC PAIN	PharmaCare Special Authority Approval Required	Oncologist (medical), Oncologist (radiation), Haematologist
KAZANO	Alogliptin / Metformin	TYPE II DIABETES	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea</li> </ul>	NA
KEPPRA	Levetiracetam	EPILEPSY	PharmaCare Special Authority Approval Required	NA
KEVZARA	Sarilumab	RHEUMATOID ARTHRITIS	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- For patients with a confirmed diagnosis of rheumatoid arthritis with persistent active disease who have not adequately responded to Methotrexate at a dose equal to or greater than 20 mg/week AND at least one other DMARD (i.e. hydroxychloroquine, leflunomide and/or sulfasalazine) for a period of 3 months or any biologic</li> </ul>	
KINERET	Anakinra	RHEUMATOID ARTHRITIS	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- For patients with a confirmed diagnosis of rheumatoid arthritis with persistent active disease who have not adequately responded to Methotrexate at a dose equal to or greater than 20 mg/week AND at least one other DMARD (i.e. hydroxychloroquine, leflunomide and/or sulfasalazine) for a period of 3 months AND who have tried and failed Cimzia or Enbrel or Humira or Simponi or Actemra SC or Remicade or Orencia SC</li> </ul>	NA
KOMBOGLYZE	Saxagliptin / Metformin	TYPE II DIABETES	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea</li> </ul> <p>OR</p> <p>Patient has PharmaCare Special Authority approval for the requested drug</p>	NA

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KUVAN	Sapropterin	PKU	<p>ClaimSecure Special Authorization Required</p> <p>Diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive Phenylketonuria (PKU) for patients 18 years of age or under</p> <ul style="list-style-type: none"> <li>- Initial requests must indicate phenyl levels prior to starting therapy</li> <li>- Patients must demonstrate responsiveness to 30-day trial and maintain phenyl-restrictive diet during treatment</li> <li>- Renewal: Evidence of decrease blood phenylalanine concentration relative to levels prior to starting therapy</li> </ul>	NA
LANCORA	Ivabradine	HEART FAILURE	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- For add-on treatment in adult patients with stable chronic heart failure with reduced ejection fraction</li> <li>- (LVEF) ≤ 35%, who are in sinus rhythm with a resting heart rate ≥ 77 beats per minute</li> <li>- Patients with NYHA class II or III</li> <li>- Patient's heart failure is not well-managed OR patient has contraindication or intolerance to at least two of the following therapies: ACE-inhibitors, ARBs, Beta-blockers and/or Diuretics.</li> </ul> <p>OR</p> <p>Patient has PharmaCare Special Authority approval for the requested drug</p>	
LEMTRADA	Alemtuzumab	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	NA
LIORESAL INTRATHECAL (including generics)	Baclofen Intrathecal	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	NA
LIXIANA	Edoxaban	ORAL ANTICOAGULANTS	<p>ClaimSecure Special Authorization Required</p> <ol style="list-style-type: none"> <li>1) For the treatment of patients with non-valvular atrial fibrillation, treatment or prevention of deep vein thrombosis (DVT) or pulmonary embolism (PE) and</li> <li>2) Patient does not have severe renal impairment and</li> <li>3) Meets one of the following criteria:                             <ul style="list-style-type: none"> <li>- Patient has PharmaCare Special Authority approval for the requested drug (attach approval form if applicable) or</li> <li>- Patient has tried warfarin for at least two months or</li> <li>- Patient is unsuitable for warfarin because of liver damage, hypersensitivity to warfarin, inability to monitor INR, embolic event with warfarin, inability to maintain a therapeutic INR, or other contraindication to warfarin</li> </ul> </li> </ol>	NA

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LUCENTIS	Ranibizumab	AMD	ClaimSecure Special Authorization Required For treatment of: - End-stage or “wet” age-related macular degeneration (“AMD”) - Macular edema following Central or Branch Retinal Vein Occlusion - Diabetic macular edema - Pathological Myopia  - Drug administered by ophthalmologist - Lucentis will not be authorized concomitantly with verteporfin for treatment of the same eye. - Validate site of administration - Authorization period of 1 year	NA
LUPRON DEPOT	Leuprolide	HORMONE THERAPY	PharmaCare Special Authority Approval Required	Paediatric endocrinologists
MAVENCLAD	Cladribine	RELAPSE REMITTING MULTIPLE SCLEROSIS	ClaimSecure Special Authorization Required - Diagnosis of relapsing remitting multiple sclerosis - EDSS value required - Failure or intolerance to one or more therapies for multiple sclerosis i.e. Aubagio, Avonex, Betaseron, Copaxone, Extavia, Plegridy, Rebif, Tecfidera	
MAVIRET	Glecaprevir/ Pibrentasvir	CHRONIC HEPATITIS C	ClaimSecure Special Authorization Required 1) Treatment naïve or treatment-experienced adult patients with chronic hepatitis C genotype 1-6 infections with: -Quantitative Hepatitis C Virus Ribonucleic Acid (HCV RNA) value within the last 6 months -Fibrosis stage F2 or greater (Metavir scale or equivalent)	NA
MIRAPEX	Pramipexole	PARKINSON'S DISEASE	PharmaCare Special Authority Approval Required	NA
MOVAPO	Apomorphine hydrochloride	PARKINSON'S DISEASE	ClaimSecure Special Authorization Required - For patients with advanced Parkinson’s disease who have tried and failed levodopa/carbidopa and at least one of the following: Comtan, Mirapex, Parlodel, Requip, Azilect	NA
NEORAL (including generics)	Cyclosporine	IMMUNOSUPPRESSANT	PharmaCare Special Authority Approval Required	Endocrinologist
NESINA	Alogliptin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea	NA
NEULASTA	Pegfilgrastim	NEUTROPENIA	ClaimSecure Special Authorization Required - Neutropenia associated with chemotherapy, transplant, AIDS	NA



### ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
NEUPOGEN	Filgrastim	NEUTROPENIA	ClaimSecure Special Authorization Required - Neutropenia associated with chemotherapy, transplant, HIV/AIDS, stem cell mobilization - Severe chronic neutropenia	NA

### ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
NORDITROPEN NORDIFLEX	Somatropin	GROWTH HORMONE DEFICIENCY	PharmaCare Special Authority Approval Required	NA
NUCALA	Mepolizumab	SEVERE PERSISTENT ASTHMA	<p>ClaimSecure Special Authorization Required</p> <p>For the treatment of severe persistent asthma in patients 18 years of age or older that meet the following criteria:</p> <ul style="list-style-type: none"> <li>-non-smoker for at least the past 6 months</li> <li>-diagnosed with severe persistent asthma</li> <li>-inadequately controlled on high dose inhaled corticosteroids and an additional asthma controller (such as beta agonist or leukotriene receptor antagonist)</li> <li>- experienced more than 1 asthma exacerbations in the past 12 months</li> <li>-recent blood eosinophil level must be &gt;150 cells/uL in the past 3 months or &gt;300 cells/uL in the past 12 months</li> </ul> <p>Renewal Criteria:</p> <ul style="list-style-type: none"> <li>-decrease in asthma exacerbations, decrease in rescue medications, improvement of symptoms, continue to maintain non-smoking status</li> </ul> <p>Approval duration: 1 year</p>	NA
NUTROPIN	Somatropin	GROWTH HORMONE DEFICIENCY	PharmaCare Special Authority Approval Required	NA
OCALIVA	Obeticholic acid	Primary biliary cholangitis (PBC)	<p>ClaimSecure Special Authorization Required</p> <p>For the treatment of primary biliary cholangitis in adults:</p> <ul style="list-style-type: none"> <li>-In combination with URSO/URSO DS in patients who have had an inadequate response to an appropriate dose of URSO/URSO DS for at least 1 year OR</li> <li>-As monotherapy in patients who are intolerant to URSO/URSO DS</li> </ul> <p>OR</p> <p>Patient has PharmaCare Special Authority approval for the requested drug</p>	NA
OCPHYL SANDOSTATIN	Octreotide	<ol style="list-style-type: none"> <li>1) Metastatic Carcinoid Syndrome</li> <li>2) Vasoactive Intestinal Peptide-Secreting Tumour (VIPoma)</li> <li>3) Acromegaly</li> <li>4) Emergency management for the bleeding of Gastro-oesophageal varices</li> <li>5) Prevention of complications following pancreatic surgery</li> </ol>	<p>ClaimSecure Special Authorization Required</p> <ol style="list-style-type: none"> <li>1) Treatment of severe diarrhea and flushing in patients with carcinoid or VIP secreting tumours who are adequately controlled with subcutaneously administered Sandostatin</li> <li>2) For acromegalic patients are adequately controlled with subcutaneously administered Sandostatin OR those in whom surgery, radiotherapy or dopamine agonist treatment is inappropriate or ineffective, or in the interim period until radiotherapy becomes fully effective</li> </ol>	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
OCREVUS	Ocrelizumab	PRIMARY PROGRESSIVE MULTIPLE SCLEROSIS	<p>ClaimSecure Special Authorization Required</p> <p><u>Initial Criteria:</u></p> <p>1) Between 18-55 years of age                      2) Confirmed diagnosis of primary progressive multiple sclerosis (PPMS) according to current diagnosis criteria with an Expanded Disability Status Scale (EDSS) score between 3.0 and 6.5                      3) Patient has score of at least 2.0 on the Functional Systems scale for pyramidal system due to lower extremity findings                      4) Patient has disease duration &lt; 15 years with EDSS score &gt; 5.0 OR disease duration &lt;10 years with EDSS score ≤ 5.0</p> <p><u>Renewal Criteria:</u></p> <p>1) Patient has responded to ocrelizumab therapy                      2) Patient has EDSS score is &lt; 7.0 while on therapy</p> <p>1 year approval</p>	NA
OFEV	Nintedanib	IDIOPATHIC PULMONARY FIBROSIS	Patient has PharmaCare Special Authority approval for the requested drug	NA
OLUMIANT	Baricitinib	RHEUMATOID ARTHRITIS	<p>ClaimSecure Special Authorization Required</p> <p>- For patients with a confirmed diagnosis of rheumatoid arthritis with persistent active disease where the patient has not adequately responded to Methotrexate at a dose equal to or greater than 15 mg/week AND Leflunomide for a period of 3 months</p>	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
OMNITROPE	Somatropin	GROWTH HORMONE DEFICIENCY	PharmaCare Special Authority Approval Required	Endocrinologist
ONGLYZA	Saxagliptin	TYPE II DIABETES	ClaimSecure Special Authorization Required - For patients who have tried and failed or did not tolerate maximum doses of metformin or a sulfonylurea OR Patient has PharmaCare Special Authority approval for the requested drug	NA
OPSUMIT	Macitentan	PULMONARY ARTERIAL HYPERTENSION	ClaimSecure Special Authorization Required - For the treatment of patients with a confirmed diagnosis of pulmonary arterial hypertension functional class II or III AND who have tried and failed or cannot tolerate Revatio or Adcirca (minimum 3 months trial) ---> For WHO FC III, patients must also have tried and failed or cannot tolerate Tracleer (bosentan)  **-May be used in conjunction with phosphodiesterase-5 inhibitors (i.e. Revatio or Adcirca)	NA
ORENCIA	Abatacept	JUVENILE IDIOPATHIC ARTHRITIS, RHEUMATOID ARTHRITIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
ORILISSA	Elagolix	PELVIC PAIN ASSOCIATED WITH ENDOMETRIOSIS	ClaimSecure Special Authorization Required - For the management of pelvic pain associated with endometriosis where the patient has tried and failed or had intolerable side effects to oral contraceptives	NA
OTEZLA	Apremilast	PLAQUE PSORIASIS PSORIATIC ARTHRITIS	ClaimSecure Special Authorization Required - For patients who are 18 years and older with moderate to severe chronic plaque psoriasis with at least 10% body involvement AND who have tried and failed phototherapy AND have tried and failed or are intolerant to at least 2 systemic therapies AND who are treated by a dermatologist - For patients with a confirmed diagnosis of psoriatic arthritis with persistent active disease where the patient has not adequately responded to Methotrexate at a dose equal to or greater than 20 mg/week AND Leflunomide or Sulfasalazine for a period of 3 months	NA
OZEMPIC	Semaglutide	TYPE II DIABETES	ClaimSecure Special Authorization Required 1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea AND 2) Patient has tried and failed or cannot tolerate a DPP-4 inhibitor, SGLT2 inhibitor or TZD	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
PEGASYS	Peg interferon alfa-2b and ribavirin	CHRONIC HEPATITIS C CHRONIC HEPATITIS B	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- For all Hepatitis C patients, an initial 16 weeks will be approved. For genotypes 2 and 3, an additional 8 weeks and for all other genotypes, an additional 32 weeks will be approved if they are responsive to the initial therapy as measured by Early Viral Response (EVR) protocol</li> <li>- For chronic Hepatitis B patients with compensated liver disease, liver inflammation and evidence of viral replication (both cirrhotic and non-cirrhotic disease). An initial 16 weeks will be approved; an additional 32 weeks will be approved if there is response to the initial therapy as measured by HbeAg seroconversion or EVR protocol</li> </ul>	NA
PHEBURANE	Sodium phenylbutyrate	UREA CYCLIC DISORDER	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- Diagnosis of urea cycle disorders; AND</li> <li>- For patients who weighs <math>\geq 20</math> kg WITH a BSA <math>\leq 1.5</math> m<sup>2</sup> and prescribed with a usual recommended dose of 9.9-13.0 g/m<sup>2</sup>/day; AND</li> <li>- Patient is currently on dietary protein restrictions; AND</li> <li>- Initial request must indicate ammonia levels prior to starting therapy</li> </ul> <p>OR</p> <p>Patient has PharmaCare Special Authority approval for the requested drug</p>	Physician has Collaborative Prescribing Agreement with BC PharmaCare
PLEGRIDY	Peg interferon beta-1a	MULTIPLE SCLEROSIS	<p>ClaimSecure Special Authorization Required</p> <ol style="list-style-type: none"> <li>1) Diagnosis of Relapsing-Remitting Multiple Sclerosis (RRMS) AND</li> <li>2) EDSS value</li> </ol>	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
POSANOL	Posaconazole	FUNGAL INFECTION	<p>ClaimSecure Special Authorization Required</p> <p>1) For the prophylaxis of aspergillosis and/or candidiasis in high risk patients with prolonged neutropenia or hematopoietic stem cell transplant patients who have failed or cannot tolerate fluconazole OR</p> <p>2) For patients with invasive aspergillosis who have failed or cannot tolerate amphotericin B or itraconazole</p> <p>3) For the treatment of Oropharyngeal Candidiasis in patients who have failed treatment with two other antifungals (systemic or oral or combination)</p>	NA
PRADAXA	Dabigatran	ORAL ANTICOAGULANTS	<p>ClaimSecure Special Authorization Required</p> <p>1) For the treatment of patients with non-valvular atrial fibrillation, treatment or prevention of deep vein thrombosis (DVT) or pulmonary embolism (PE) and</p> <p>2) Patient does not have severe renal impairment and</p> <p>3) Meets one of the following criteria:</p> <ul style="list-style-type: none"> <li>- Patient has PharmaCare Special Authority approval for the requested drug (attach approval form if applicable) or</li> <li>- Patient has tried warfarin for at least two months or</li> <li>- Patient is unsuitable for warfarin because of liver damage, hypersensitivity to warfarin, inability to monitor INR, embolic event with warfarin, inability to maintain a therapeutic INR, or other contraindication to warfarin</li> </ul>	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
PRALUENT	Alirocumab	PCSK9 INHIBITORS	<p>ClaimSecure Special Authorization Required</p> <p><b>CLICK CELL TO SEE FULL CRITERIA</b></p> <p><u>Initial Criteria (6 months approval):</u></p> <ul style="list-style-type: none"> <li>- LDL-C must be &gt; 2.6 mmol/L on current therapy</li> <li>- Prior therapy of at least 3 months with ONE statin at maximally tolerated dose is required</li> <li>- Current lipid therapy continued with PCSK9 inhibitor unless contraindicated</li> <li>- Intolerance to or not at maximum statin dose due to:                             <ul style="list-style-type: none"> <li>--&gt; Intolerable and persistent documented muscle symptoms (pain, weakness, cramps)</li> <li>--&gt; Creatinine kinase (CK) levels greater than 10x upper normal limit and/or rhabdomyolysis</li> <li>--&gt; Persistent serum transaminase levels greater than 3x upper normal limit</li> <li>--&gt; Patient is non-adherent to statin therapy</li> </ul> </li> </ul> <p>AND</p> <p>For the patients with the following conditions:</p> <ol style="list-style-type: none"> <li>1) Atherosclerotic Cardiovascular Disease and ≥ 18 years of age</li> <li>2) Heterozygous Familial Hypercholesterolemia and ≥ 18 years of age                             <ul style="list-style-type: none"> <li>-Total cholesterol &gt; 7.5 mmol/L (adult patient) or 6.7 mmol/L (child aged &lt;16 years), OR LDL-C &gt;4.9 mmol/L (adult patients) or &gt;4 mmol/L (child aged &lt;16 years) or</li> <li>-Tendon xanthomas in the patient or any of patients of first or second degree relatives or</li> <li>-Confirmation of condition by genetic analysis or</li> <li>-Family history of heart attack before the age of:                                     <ul style="list-style-type: none"> <li>-50 years, in any first or second degree relative, or</li> <li>-60 years in any first degree relative or</li> </ul> </li> <li>-Family history of plasma total cholesterol &gt;7.5 mmol/L in any first or second degree relative</li> </ul> </li> <li>3) Homozygous Familial Hypercholesterolemia and ≥ 12 years of age                             <ul style="list-style-type: none"> <li>-Currently treated with diet and other lipid lowering therapies (maximally tolerated statin and/or ezetimibe dose) or</li> <li>-Confirmation of condition by genetic analysis or</li> </ul> </li> </ol>	NA
PRISTIQ	Desvenlafaxine	DEPRESSION	<p>ClaimSecure Special Authorization Required</p> <p>Treatment of patient 18 years or older with major depressive disorder who has tried and failed and/or was intolerant to at least two SSRIs or SNRIs (e.g. escitalopram, citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine, duloxetine)</p>	Psychiatrist
PULMOZYME	Dornase alfa	CYSTIC FIBROSIS (Pneumonia)	<p>ClaimSecure Special Authorization Required</p> <p>For treatment in patients, aged 5 years or older, diagnosed with cystic fibrosis and who have a forced vital lung capacity more than 40%</p>	NA
QUINSAIR	Levofloxacin	CYSTIC FIBROSIS (Pneumonia)	<p>ClaimSecure Special Authorization Required</p> <p>For patients aged 18 or over with confirmed Cystic Fibrosis and pulmonary infection with Pseudomonas aeruginosa, who have tried and failed or did not tolerate prior therapy with TOBI inhaled solution or TOBI Podhaler</p>	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
REBIF	Interferon beta-1a	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
RELISTOR	Methylnaltrexone bromide	OPIOID INDUCED CONSTIPATION	ClaimSecure Special Authorization Required Patients with Opioid-Induced Constipation (OIC) receiving palliative care, who have tried and failed traditional laxatives and/or enemas	NA
REMICADE	Infliximab	IMMUNE-MEDIATED INFLAMMATORY DISORDERS	ClaimSecure Special Authorization Required - For patients with fistulizing Crohn's disease or patients with moderate to severe Crohn's disease who have failed to respond to corticosteroids AND an immunosuppressant agent (azathioprine, 6-mercaptopurine, methotrexate, or cyclosporine) - Patients with active ulcerative colitis who failed or are intolerant to oral corticosteroid therapy and a 5-ASA product OR immunosuppressants (azathioprine, 6-mercaptopurine, methotrexate, or cyclosporine) - For patients with a confirmed diagnosis of rheumatoid arthritis with persistent active disease where the patient has not adequately responded to Methotrexate at a dose equal to or greater than 20 mg/week AND at least one other DMARD (i.e. hydroxychloroquine, leflunomide and/or sulfasalazine) for a period of 3 months - For patients with a confirmed diagnosis of psoriatic arthritis with persistent active disease where the patient has not adequately responded to Methotrexate at a dose equal to or greater than 20 mg/week AND Leflunomide or Sulfasalazine for a period of 3 months - For patients with confirmed diagnosis of active ankylosing spondylitis where symptoms are uncontrolled by NSAIDs and the BASDAI score is greater than or equal to 4 - For patients who are 18 years and older with moderate to severe chronic plaque psoriasis with at least 10% body involvement AND who have tried and failed phototherapy AND who have tried and failed or are intolerant to at least 2 systemic therapies AND who are being treated by a dermatologist OR Patient has PharmaCare Special Authority approval for the requested drug	NA
REMODULIN	Treprostinil	PULMONARY ARTERIAL HYPERTENSION	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
RENFLIXIS	Infliximab	IMMUNE-MEDIATED INFLAMMATORY DISORDERS	PharmaCare Special Authority Approval Required	Pediatric rheumatologists have an exemption



## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
REPATHA	Evolocumab	PCSK9 INHIBITORS	<p>ClaimSecure Special Authorization Required</p> <p><b>CLICK CELL TO SEE FULL CRITERIA</b></p> <p><u>Initial Criteria (6 months approval):</u></p> <ul style="list-style-type: none"> <li>- LDL-C must be &gt; 2.6 mmol/L on current therapy</li> <li>- Prior therapy of at least 3 months with ONE statin at maximally tolerated dose is required</li> <li>- Current lipid therapy continued with PCSK9 inhibitor unless contraindicated</li> <li>- Intolerance to or not at maximum statin dose due to:                             <ul style="list-style-type: none"> <li>--&gt; Intolerable and persistent documented muscle symptoms (pain, weakness, cramps)</li> <li>--&gt; Creatinine kinase (CK) levels greater than 10x upper normal limit and/or rhabdomyolysis</li> <li>--&gt; Persistent serum transaminase levels greater than 3x upper normal limit</li> <li>--&gt; Patient is non-adherent to statin therapy</li> </ul> </li> </ul> <p>AND</p> <p>For the patients with the following conditions:</p> <ol style="list-style-type: none"> <li>1) Atherosclerotic Cardiovascular Disease and ≥ 18 years of age</li> <li>2) Heterozygous Familial Hypercholesterolemia and ≥ 18 years of age                             <ul style="list-style-type: none"> <li>-Total cholesterol &gt; 7.5 mmol/L (adult patient) or 6.7 mmol/L (child aged &lt;16 years), OR LDL-C &gt;4.9 mmol/L (adult patients) or &gt;4 mmol/L (child aged &lt;16 years) or</li> <li>-Tendon xanthomas in the patient or any of patients of first or second degree relatives or</li> <li>-Confirmation of condition by genetic analysis or</li> <li>-Family history of heart attack before the age of:                                     <ul style="list-style-type: none"> <li>-50 years, in any first or second degree relative, or</li> <li>-60 years in any first degree relative or</li> </ul> </li> <li>-Family history of plasma total cholesterol &gt;7.5 mmol/L in any first or second degree relative</li> </ul> </li> <li>3) Homozygous Familial Hypercholesterolemia and ≥ 12 years of age                             <ul style="list-style-type: none"> <li>-Currently treated with diet and other lipid lowering therapies (maximally tolerated statin and/or ezetimibe dose) or</li> <li>-Confirmation of condition by genetic analysis or</li> </ul> </li> </ol>	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
REQUIP	Ropinirole	PARKINSON'S DISEASE	PharmaCare Special Authority Approval Required	NA
RETISERT	Fluocinolone acetonide	UVEITIS	ClaimSecure Special Authorization Required For the treatment of chronic Non-Infectious Posterior Uveitis in patients who have tried and failed oral prednisone or an equivalent corticosteroid alone and/or an immunosuppressive agent (cyclosporine, azathioprine, methotrexate etc.)	NA
REVATIO and its generics	Sildenafil low dose	PULMONARY ARTERIAL HYPERTENSION	ClaimSecure Special Authorization Required For patients with a confirmed diagnosis of pulmonary arterial hypertension functional class II or III - Failure to conventional therapy (i.e. calcium channel blockers, anticoagulation with warfarin, diuretics, digoxin, supplemental oxygen)	NA
REVOLADE	Eltrombopag Olamine	THROMBOCYTOPENIA	ClaimSecure Special Authorization Required - For adult patients who are splenectomised and have tried and failed corticosteroids and immunoglobulins - For adult patients who are non-splenectomised (where surgery is contraindicated) and have tried and failed corticosteroids and immunoglobulins - For pediatric patients 1 year of age or older who have tried and failed corticosteroids and immunoglobulins - Platelet counts less than 30 x 10 <sup>9</sup> /L - Adults: Maximum approval is 1 year of continuous treatment where therapy should be discontinued thereafter should platelet count exceed 400 x 10 <sup>9</sup> /L - Pediatrics: Maximum approval is 9 months of continuous treatment where therapy should be discontinued thereafter should platelet count exceed 400 x 10 <sup>9</sup> /L	NA
RILUTEK and its generics	Riluzole	ALS	ClaimSecure Special Authorization Required Patients with symptoms of less than 5 years AND who still have a vital lung capacity of 60% or more in the absence of tracheotomy  Approval duration: 6 months	NA
RISPERDAL CONSTA	Risperidone	ANTIPSYCHOTIC	PharmaCare Special Authority Approval Required	NA
RITUXAN	Rituximab	GRANULOMATOSIS, RHEUMATOID ARTHRITIS	PharmaCare Special Authority Approval Required	NA
SAIZEN	Somatropin	GROWTH HORMONE DEFICIENCY	PharmaCare Special Authority Approval Required	NA
SATIVEX	Tetrahydro-cannabinol and cannabidiol buccal spray	MULTIPLE SCLEROSIS	ClaimSecure Special Authorization Required Adult MS patients with neuropathic pain who have tried other medications such as analgesics, opioids, antidepressants or anti-convulsants, with little or no effect	NA
SEGLUROMET	Ertugliflozin and Metformin	DIABETES MELLITUS	ClaimSecure Special Authorization Required - For treatment of type-2 diabetic persons where metformin and a sulfonylurea are contraindicated, not tolerated or ineffective	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
SENSIPAR and its generics	Cinacalcet	HYPERPARATHYROIDISM	ClaimSecure Special Authorization Required For patients with hyperparathyroidism secondary to Chronic Kidney Disease with parathyroid hormone levels greater than 33pmol/L or 300pg/mL	NA
SIGNIFOR	Pasireotide	CUSHING'S DISEASE	ClaimSecure Special Authorization Required <u>Initial Criteria</u> For the treatment of Cushing's Disease in adult patients: - tried and failed or are experiencing recurrent disease despite prior surgical intervention OR - whose condition or who have comorbidities that render surgery inappropriate Baseline urinary free cortisol levels - 6 months approval  <u>Renewal Criteria</u> Documentation of clinical benefits with Signifor: - Normalization of urinary free cortisol OR - More than 50% decrease in urinary free cortisol	NA
SILIQ	Brodalumab	PLAQUE PSORIASIS	ClaimSecure Special Authorization Required - For patients who are 18 years and older with moderate to severe chronic plaque psoriasis with at least 10% body involvement AND who have tried and failed phototherapy AND have tried and failed or are intolerant to at least 2 systemic therapies AND who are being treated by a dermatologist	NA
SIMPONI SC	Golimumab	IMMUNE-MEDIATED INFLAMMATORY DISORDERS	PharmaCare Special Authority Approval Required	NA
SIMPONI IV	Golimumab	IMMUNE-MEDIATED INFLAMMATORY DISORDERS	ClaimSecure Special Authorization Required - For patients with a confirmed diagnosis of rheumatoid arthritis with persistent active disease where the patient has not adequately responded to Methotrexate at a dose equal to or greater than 20 mg/week AND at least one other DMARD (i.e. hydroxychloroquine, leflunomide and/or sulfasalazine) for a period of 3 months - For patients with confirmed diagnosis of active ankylosing spondylitis where symptoms are uncontrolled by NSAIDs and the BASDAI score is greater than or equal to 4 - For patients with a confirmed diagnosis of psoriatic arthritis with persistent active disease where the patient has not adequately responded to Methotrexate at a dose equal to or greater than 20 mg/week AND Leflunomide or Sulfasalazine for a period of 3 months	NA
SKYRIZI	Risankizumab	PLAQUE PSORIASIS	ClaimSecure Special Authorization Required For patients 18 years and older with moderate to severe chronic plaque psoriasis with at least 10% body involvement who have tried and failed phototherapy AND have tried and failed or are intolerant to at least 2 other biologic therapies (eg. Humira, Enbrel, Remicade, Stelara, etc.) AND who are being treated by a dermatologist	

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
SOLIQUA	Insulin glargine/ lixisenatide	DIABETES MELLITUS	ClaimSecure Special Authorization Required - For adults with type 2 diabetes mellitus who are inadequately controlled on basal insulin	NA
SOMATULINE	Lanreotide	ACROMEGALY  ENTEROPANCREATIC NEUROENDOCRINE TUMORS	ClaimSecure Special Authorization Required - For the treatment of acromegaly in patients who have tried and failed or are ineligible for surgery and/or radiation therapy and other medical therapies - For the treatment enteropancreatic neuroendocrine tumors characterized as Grade 1 or Grade 2 (equivalent to Ki67 < 10%) that are unresectable, locally advanced or metastatic	NA
SOMAVERT	Pegvisomant	ACROMEGALY	ClaimSecure Special Authorization Required 1) Tried and failed surgery and/or radiation therapy and other medical therapies OR 2) Ineligible for surgery and/or radiation therapy and other medical therapies	NA
SOVALDI	Sofosbuvir	CHRONIC HEPATITIS C	PharmaCare Special Authority Approval Required	NA
STEGLATRO	Ertugliflozin	DIABETES MELLITUS	ClaimSecure Special Authorization Required - For treatment of type-2 diabetic persons where metformin and a sulfonylurea are contraindicated, not tolerated or ineffective	NA
STEGLUJAN	Ertugliflozin and sitagliptin	DIABETES MELLITUS	ClaimSecure Special Authorization Required - For treatment of type-2 diabetic persons where metformin and a sulfonylurea are contraindicated, not tolerated or ineffective	NA
STALEVO	Carbidopa/Entacapone/ Levodopa	PARKINSON'S DISEASE	PharmaCare Special Authority Approval Required	NA
STELARA	Ustekinumab	PSORIASIS	PharmaCare Special Authority Approval Required	NA
SYMBICORT	Budesonide / formoterol	Asthma/COPD	ClaimSecure Special Authorization Required 1) Tried and failed inhaled corticosteroid and short-acting beta agonist, or 2) Patient has PharmaCare Special Authority approval for the requested drug	Allergists or Respiriologists
SYNJARDY	Empagliflozin/Metformin	TYPE II DIABETES	ClaimSecure Special Authorization Required - Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea	NA
TALTZ	Ixekizumab	PSORIASIS	PharmaCare Special Authority Approval Required	NA
TECFIDERA	Dimethyl fumarate	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
TOBI NEBULES (including generics)	Tobramycin	CYSTIC FIBROSIS	PharmaCare Special Authority Approval Required	NA
TOBI PODHALER	Tobramycin	CYSTIC FIBROSIS	PharmaCare Special Authority Approval Required	NA
TOCTINO	Alitretinoin	SEVERE CHRONIC HAND ECZEMA	PharmaCare Special Authority Approval Required	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
TRACLEER (including generics)	Bosentan	PULMONARY ARTERIAL HYPERTENSION	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
TRAJENTA	Linagliptin	TYPE II DIABETES	ClaimSecure Special Authorization Required 1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea or 2) Patient has PharmaCare Special Authority approval for the requested drug	NA
TREMFYA	Guselkumab	PLAQUE PSORIASIS	ClaimSecure Special Authorization Required For patients who are 18 years and older with moderate to severe chronic plaque psoriasis: 1) with at least 10% body involvement AND 2) who have tried and failed phototherapy AND 3) tried and failed or are intolerant to at least 2 systemic therapies AND 4) who are treated by a dermatologist	NA
TRINTELLIX	Vortioxetine	DEPRESSION	ClaimSecure Special Authorization Required Treatment of patient 18 years or older with major depressive disorder who has tried and failed and/or was intolerant to at least two SSRIs or SNRIs (e.g. escitalopram, citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine, duloxetine)	Psychiatrist
TRULICITY	Dulaglutide	TYPE II DIABETES	ClaimSecure Special Authorization Required 1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea AND 2) Patient has tried and failed or cannot tolerate a DPP-4 inhibitor, SGLT2 inhibitor or TZD	NA
TYSABRI	Natalizumab	MULTIPLE SCLEROSIS	PharmaCare Special Authority Approval Required	NA
UPTRAVI	Selexipag	PULMONARY ARTERIAL HYPERTENSION	ClaimSecure Special Authorization Required - For treatment of Pulmonary Arterial Hypertension (PAH) WHO functional class (FC) II–III (idiopathic, heritable, or associated with connective tissue disease or congenital heart disorders) - For patients who have tried and failed or cannot tolerate at least one ERA (i.e. Tracleer, Volibris, Opsumit) or PDE-5 inhibitor (i.e. Revatio, Adcirca) - May be used as monotherapy OR an add-on to existing ERA/PDE-5 inhibitor OR triple combination therapy OR Patient has PharmaCare Special Authority approval for the requested drug	NA

### ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
VALCYTE and its generics	Valganciclovir	CMV	ClaimSecure Special Authorization Required - For the treatment of retinitis caused by the cytomegalovirus (CMV) in HIV or immunocompromised patients - For the prevention of CMV disease in solid organ transplant patients at risk (i.e. risk is defined as donor +ve/recipient -ve for CMV, or recipient +ve post-active treatment of CMV disease with IV ganciclovir, or recipient +ve in patients receiving antilymphocyte antibody [ALA]). OR Patient has PharmaCare Special Authority approval for the requested drug	Physician has Collaborative Prescribing Agreement with BC PharmaCare
VANCOGIN	Vancomycin	CLOSTRIDIUM DIFFICILE	PharmaCare Special Authority Approval Required	NA
VEMLIDY	Tenofovir alafenamide	CHRONIC HEPATITS B	ClaimSecure Special Authorization Required -For the treatment of chronic hepatitis B in adults with compensated liver disease	NA

## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
VFEND (including generics)	Voriconazole	FUNGAL INFECTION	PharmaCare Special Authority Approval Required	NA
VICTOZA	Liraglutide	TYPE II DIABETES	ClaimSecure Special Authorization Required 1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea AND 2) Patient has tried and failed or cannot tolerate a DPP-4 inhibitor, SGLT2 inhibitor or TZD	NA
VIMPAT	Lacosamide	EPILEPSY	PharmaCare Special Authority Approval Required	NA
VIREAD (including generics)	Tenofovir	CHRONIC HEPATITIS B	PharmaCare Special Authority Approval Required	NA
VISUDYNE	Verteprofine	AMD	ClaimSecure Special Authorization Required For the treatment of age-related macular degeneration in patients with neovascularization of 50% or more on the macular surface.	NA
VOLIBRIS	Ambrisentan	PULMONARY ARTERIAL HYPERTENSION	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare
VOSEVI	Sofosbuvir/ Velpatasvir/ Voxilaprevir	CHRONIC HEPATITIS C	Patient has PharmaCare Special Authority approval for the requested drug	NA
XARELTO	Rivaroxaban	ORAL ANTICOAGULANTS	ClaimSecure Special Authorization Required 1) For the treatment of patients with non-valvular atrial fibrillation, treatment or prevention of deep vein thrombosis (DVT) or pulmonary embolism (PE) and 2) Patient does not have severe renal impairment and 3) Meets one of the following criteria: - Patient has PharmaCare Special Authority approval for the requested drug (attach approval form if applicable) or - Patient has tried warfarin for at least two months or - Patient is unsuitable for warfarin because of liver damage, hypersensitivity to warfarin, inability to monitor INR, embolic event with warfarin, inability to maintain a therapeutic INR, or other contraindication to warfarin	NA
XELJANZ	Tofacitinib	RHEUMATOID ARTHRITIS	PharmaCare Special Authority Approval Required	Physician has Collaborative Prescribing Agreement with BC PharmaCare

### ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
XEOMIN	IncobotulinumtoxinA	BOTOX/XEOMIN	<p>ClaimSecure Special Authorization Required</p> <p>For adults with one of the following conditions:</p> <ul style="list-style-type: none"> <li>-Treatment of Blepharospasm</li> <li>-Reduce symptoms and signs of Cervical Dystonia (spasmodic torticollis)</li> <li>-Treatment of Upper Limb Spasticity associated with stroke</li> <li>-Management of Focal Spasticity</li> </ul> <p>OR</p> <p>Patient has PharmaCare Special Authority approval for the requested drug</p> <p>Approval for 2 years</p>	Physician has Collaborative Prescribing Agreement with BC PharmaCare
XIAFLEX	Collagenase Clostridium Histolyticum	DUPUYTREN'S CONTRACTURE  PEYRONIE'S DISEASE	<p>ClaimSecure Special Authorization Required</p> <ul style="list-style-type: none"> <li>- For patients with a confirmed diagnosis of Dupuytren's Contracture with a palpable cord;</li> </ul> <p>Approval maximum: 3 injections per finger</p> <ul style="list-style-type: none"> <li>- For the treatment of patients with Peyronie's disease with a palpable plaque and curvature deformity of at least 30 degrees; Maximum lifetime approval of 8 injections</li> </ul>	NA



## ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
XIGDUO	Dapagliflozin / Metformin	TYPE II DIABETES	ClaimSecure Special Authorization Required - Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea	NA
XOLAIR	Omalizumab	ASTHMA or CHRONIC IDIOPATHIC URTICARIA	ClaimSecure Special Authorization Required - For allergic asthma, Xolair vials will only be considered if patient has a latex allergy or contraindication to Xolair PFS - For the treatment of patients 12 years or older who have moderate to severe asthma and who are skin test positive or have in-vitro reactivity to a perennial aeroallergen with a baseline IgE level within 30-700IU/ml and who are not adequately controlled by a concomitant high-dose or maximum tolerated doses of ICS with two or more of the following drug classes: LABA, LTRA, and theophylline - For pediatric patients age 6-11 with moderate-severe persistent allergic asthma, with uncontrolled symptoms despite high doses of an inhaled corticosteroid (ICS) and/or a leukotriene receptor antagonist (LTRA); Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen; Documentation of weight and pretreatment serum IgE - For the treatment of chronic idiopathic urticarial in patients 12 years and older who remain symptomatic despite an adequate trial of a maximum-tolerated dose of H-1 antihistamine for at least 3 months. Prescriber must clearly specify the severity of symptoms (i.e. impact on quality of life, and the extent of the lesions etc.)	NA
XULTOPHY	Liraglutide / Insulin degludec	TYPE II DIABETES	ClaimSecure Special Authorization Required 1) Patient has tried and failed or cannot tolerate maximum doses of metformin or sulfonylurea AND 2) Patient has tried and failed or cannot tolerate a DPP-4 inhibitor, SGLT2 inhibitor or TZD	NA
XYREM	Sodium oxybate	NARCOLEPSY	ClaimSecure Special Authorization Required Treatment of patients with chronic symptoms of cataplexy associated with narcolepsy	NA
ZAXINE	Rifaximin	HEPATIC ENCEPHALOPATHY	Patient has PharmaCare Special Authority approval for the requested drug	NA
ZAXINE	Rifaximin	IRRITABLE BOWEL SYNDROME WITH DIARRHEA	ClaimSecure Special Authorization Required For treatment of irritable bowel syndrome with diarrhea (IBS-D) in adult patients who have tried and failed dietary and lifestyle measures and standard therapy (i.e. Imodium); lifetime approval maximum of 126 tablets	NA
ZENHALE	Mometasone / formoterol	Asthma/COPD	ClaimSecure Special Authorization Required 1) Tried and failed inhaled corticosteroid and short-acting beta agonist, or 2) Patient has PharmaCare Special Authority approval for the requested drug	Respirologist or Allergist
ZEPATIER	Elbasvir/ Grazoprevir	CHRONIC HEPATITIS C	PharmaCare Special Authority Approval Required	NA

### ClaimSecure Special Authorization Drug List for BCNU Members



Drug Name (Brand)	Drug Name (Generic)	Indication	Coverage Criteria	Specialist exempt from completing his / her portion of SA form
ZOFRAN INJ	Ondansetron	CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING	PharmaCare Special Authority Approval Required	Oncologist (medical), Oncologist (radiation)
ZOLADEX	Goserelin Acetate	ENDOMETRIOSIS	PharmaCare Special Authority Approval Required	NA
ZYVOXAM	Linezolid	HOSPITAL ACQUIRED INFECTIONS	PharmaCare Special Authority Approval Required	Infectious Disease Specialists