Cibinqo (Abrocitinib), Dupixent (Dupilumab), Rinvoq (Upadacitinib) for Atopic Dermatitis

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

Fax: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	**Fax Number:**
Prescriber Address:	**Phone Number:**
	Prescriber License Number (NOT Billing Number):

Patient First Name:	**PHIN:**	**MHSC:**
Patient Last Name:	**Patient's Date of Birth:**	

◯ **New Request** ◯ **Renewal Request**

Medication Requested

◯ Cibinqo (Abrocitinib) ◯ Dupixent (Dupilumab) ◯ Rinvoq (Upadacitinib)

Strength and Dosage Form:	**Regimen and Duration:**

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the EDS listing. Please provide the following details about how this patient meets the specific criteria for coverage. Manitoba Health may request additional documentation to support this EDS request.

For INITIAL Requests:

Diagnosis/Indication:

◯ Moderate-to-severe atopic dermatitis (AD) defined as an Eczema Area and Severity Index (EASI) Score of **16 points or higher.**

◯ Other: _____

Please provide patient's CURRENT Eczema Area and Severity Index (EASI) Score:

EASI:	Date of Result:

Please check YES or NO to the following statements:

Request for coverage is being made by or in consultation with a dermatologist, allergist, clinical immunologist, or pediatrician who has expertise in the management of moderate-to-severe AD.	◯ YES	◯ NO
Patient is 12 years of age or older.	◯ YES	◯ NO
Requested medication will not be used in combination with phototherapy or any immunomodulatory drugs (including biologics or a Janus kinase [JAK] inhibitor treatment) for moderate-to-severe AD.	◯ YES	◯ NO
Patient continues to have moderate-to-severe AD despite adequate trials of:		
Maximally tolerated medical topical therapies for AD **combined with phototherapy (where available); AND**	◯ YES	◯ NO
Maximally tolerated medical topical therapies for AD **combined with a systemic immunomodulator (methotrexate, cyclosporine, mycophenolate mofetil or azathioprine).**	◯ YES	◯ NO

Treatment history:		
Patient has had a trial of or was intolerant to phototherapy at a frequency of 3 times per week for 12 weeks.	◯ YES	◯ NO
If no, please indicate reason:		

Fill in all that apply and indicate dose, duration and response.

Patient's weight:

Immunomodulators Tried:	***Dosing Regimen Used***	***Start and End Date***	***Response to Trial***
Methotrexate 10 to 20 mg per week for 12 weeks			
Cyclosporine 2.5 to 5 mg/kg/day for 12 weeks			
Mycophenolate mofetil 1 g twice daily for 12 weeks			
Azathioprine 1.5 to 2.5 mg/kg/day for 12 weeks			

Additional Relevant Clinical Information:

For RENEWAL Requests:

Please provide patient's CURRENT Eczema Area and Severity Index (EASI) Score:	
EASI:	Date of Result:

☐ **I have discussed with the patient that the purpose of releasing their information to Manitoba Health, Seniors and Long-Term Care is to obtain Exception Drug Status for prescription coverage.**

Prescriber Signature and Date:	
Date:	Prescriber Signature: