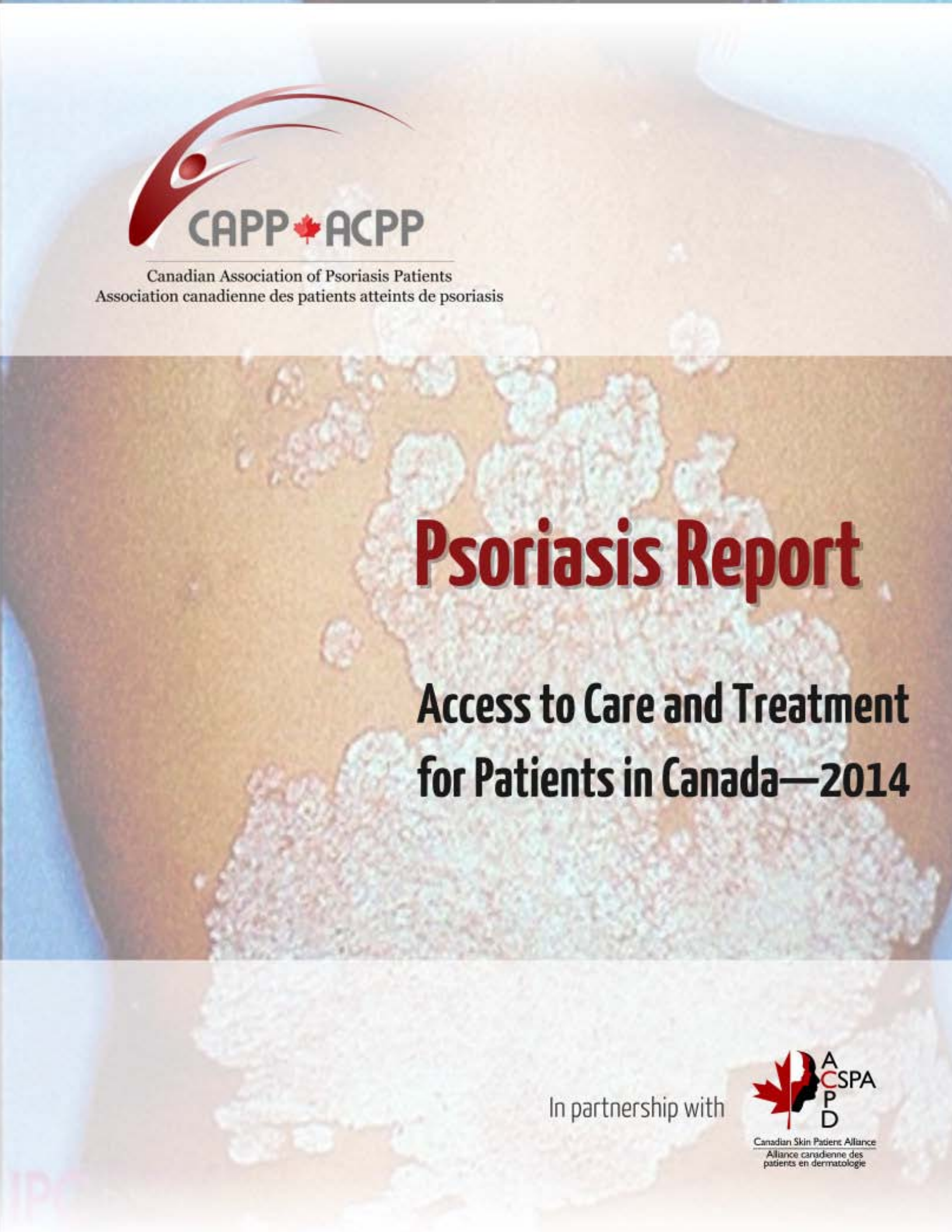


CAPP ACPP

Canadian Association of Psoriasis Patients
Association canadienne des patients atteints de psoriasis

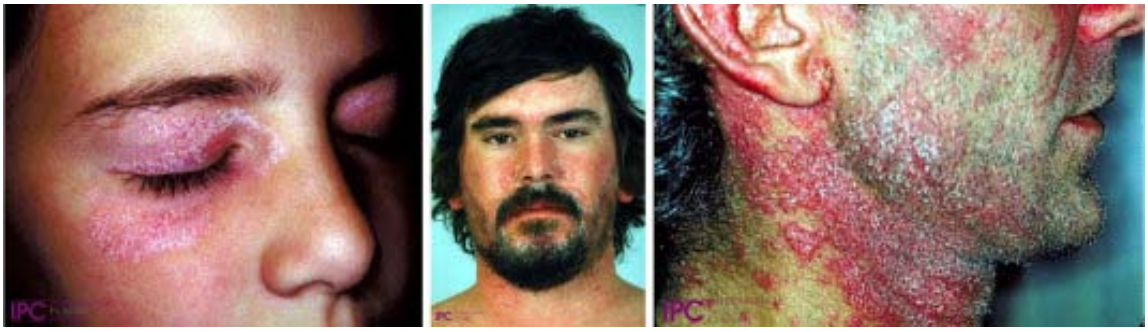
Psoriasis Report

Access to Care and Treatment for Patients in Canada—2014

In partnership with

ACSPA
ACPD

Canadian Skin Patient Alliance
Alliance canadienne des patients en dermatologie



Executive summary

Psoriasis and psoriatic arthritis are chronic, debilitating diseases. While there are no permanent cures, there are many effective forms of treatment which improve people's ability to live normal, healthy lives.[1] This Report Card measures access to dermatological care, phototherapy services, and medications to treat psoriasis and psoriatic arthritis.

In 2014 The World Health Organization (WHO) with Canada's support passed the Psoriasis Resolution which underlines the importance for Member States to "continue addressing key risk factors" for this "chronic, non-communicable, painful, disfiguring, and disabling disease for which there is no cure". It underscores that "too many people in the world suffer needlessly from psoriasis due to incorrect or delayed diagnosis, inadequate treatment options and insufficient access to care." [2]

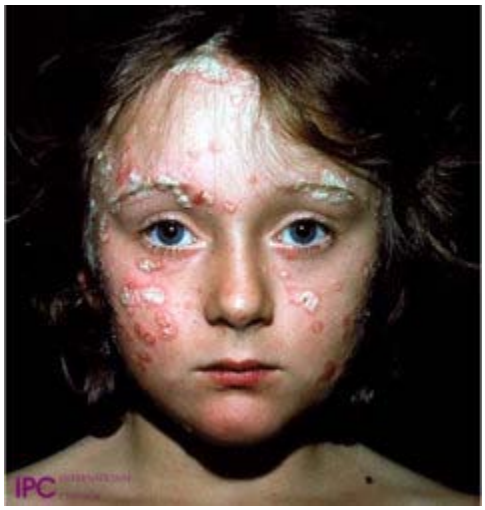
While Canada as a whole has taken steps to improve access to dermatological care, psoriasis patients face long wait times for routine medical consultations. The majority of provinces and territories still lack sufficient numbers of dermatologists and in all regions rural populations are especially disadvantaged. Of great concern are poor access to phototherapy

[1] Gupta, Ashok Kumar, et al. Effectiveness of Conventional Drug Therapy of Plaque Psoriasis in the Context of Consensus Guidelines: A Prospective Observational Study in 150 Patients. *Annals of Dermatology* 25.2 (2013): 156-162.

[2] WHA 67.9

– an inexpensive and effective treatment for psoriasis – and escalating barriers to access to new medications which are burdensome for the health system, patients and dermatologists.

Scope of problem



Psoriasis and psoriatic arthritis affect approximately one million Canadians.[3] Because of its highly visible nature, psoriasis has widespread effects on patients and their families. The psychological impact of the disease, including feelings of stigmatization, isolation, anxiety and depression, can have an even greater impact on patients' everyday lives than do the physical symptoms.[4]

Canadian research shows that the economic burden of psoriasis is high. The total annual cost of moderate-to-severe psoriasis has been estimated at $1.7 billion in direct costs and lost productivity.[5] Psoriasis treatment costs more than $30 million annually for phototherapy treatments alone – an expenditure that could be reduced by including home phototherapy units as an insured service.[6]

Between 10 and 30 per cent of psoriasis sufferers develop psoriatic arthritis, a chronic inflammation of the joints. When diagnosed early and treated appropriately with medication, surgery (in some cases), exercise, rest and joint protection, severe damage to the joints can be avoided.

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[3] Levy, A. R., et al. Economic burden of moderate to severe plaque psoriasis in Canada. *International Journal of Dermatology*, 51 (2012): 1432–1440.

[4] Bewley, A., et al. Psychosocial and symptomatic burden of psoriasis for patients in Europe, the USA and Canada. *Abstract presented at: EADV Congress, Prague*. 2012.

[5] Levy, A. R., et al. Economic burden of moderate to severe plaque psoriasis in Canada. *International Journal of Dermatology*, 51 (2012): 1432–1440.

[6] Medical Advisory Secretariat. Ultraviolet phototherapy management of moderate-to-severe plaque psoriasis: an evidence-based analysis. *Ontario Health Technology Assessment Series* 9.27 (2009)

Issues

While effective treatments are available for both psoriasis and psoriatic arthritis, many patients experience difficulties obtaining them. There are deficiencies and disparities in access to dermatological care and treatment across the country:

- Long wait times and shortages of dermatologists threaten the ability of patients to receive the medical attention they need;
- A severe lack of phototherapy clinics, and refusal of governments to cover home phototherapy, puts this effective option out of reach of many psoriasis patients;
- Restrictions on access to newer drugs create barriers to access and often simply defer costs to payers. Concerns with ineffectiveness, toxicities and interactions of older medications put patients at risk.

Two other issues of growing concern to psoriasis patients — the changing environment of private health benefits plans and subsequent entry biological drugs — continue to be monitored by CAPP.

This Report Card was developed to measure how well psoriasis patients are able to access a reasonable level of dermatological care and treatment. Its findings serve as a foundation for the advocacy work of the Canadian Association of Psoriasis Patients and other stakeholders to improve patients' access to effective care and treatment for these debilitating diseases.

Recommendations

The Canadian Association of Psoriasis Patients (CAPP) calls on provincial and territorial governments to take the lead, in collaboration with patients, health professionals and other stakeholders, to implement the following recommendations.

1. **Improve access to dermatological care**. Reduce wait times for routine consultation by a dermatologist to 5 weeks within the next 3 years by achieving the minimum ratio recommended by the Royal College of Physicians and Surgeons of Canada of 1 full-time medical dermatologist for every 62,500 residents.
2. **Improve access to phototherapy**. Ensure that every psoriasis patient has access to phototherapy by providing a clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.
3. **Improve access to medications.** Fund *all* drugs deemed to be the standard of care without restrictions and without a time-consuming application process, allowing physicians, together with their patients, to make the decision about which therapies are appropriate.

Acknowledgements

Many contributors made this Report Card possible. In particular, the Canadian Association of Psoriasis Patients (CAPP) would like to thank Dr. Evert Tuyp and Dr. Gordon Searles for sharing their knowledge and expertise. The CSPA's Medical Advisory Board also provided valuable information and advice and each member checked the section corresponding to his /her province for accuracy.

Research and writing of the draft Report Card was performed by Turner & Associates Inc. and Suzanne Lepage Consulting.

The images of psoriasis patients used to illustrate this Report Card are made available courtesy of the International Psoriasis Council, 1034 S. Brentwood Blvd., Suite 600, St. Louis, MO USA 63117, whose support we gratefully acknowledge.

The Report Card was developed with the assistance of CAPP Board member Christine Clarke, administrative support and project coordination from CAPP staff members Helen Crawford and Sheri Pilon, and led by Christine Janus, CEO and Executive Director of CAPP. Thanks also to Stephen Clarke of Solara360 for the layout.

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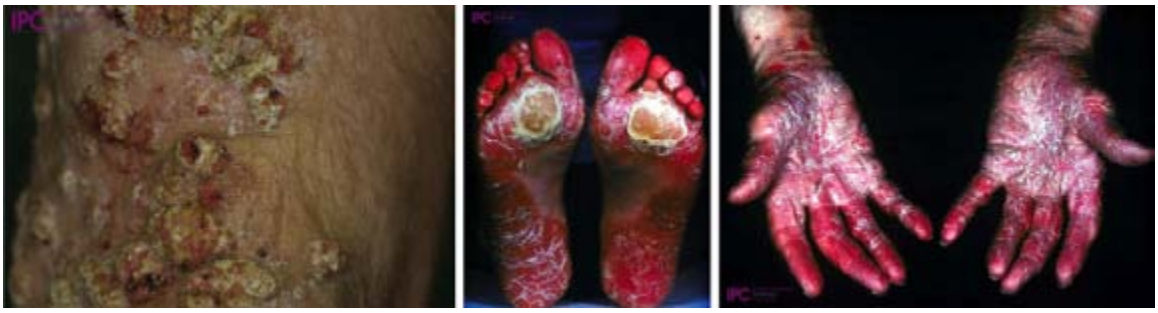


Introduction

Scope of the problem

Psoriasis is a chronic, debilitating disease which affects approximately one million Canadians.[7] Lesions on the skin, nails and sometimes the joints (known as psoriatic arthritis) are caused by the person's immune system attacking their body's tissues. Although patients experience a waxing and waning of symptoms, the disease has a lifelong course. While there is no permanent cure there are many effective forms of treatment that improve people's ability to live normal, healthy lives.[8]

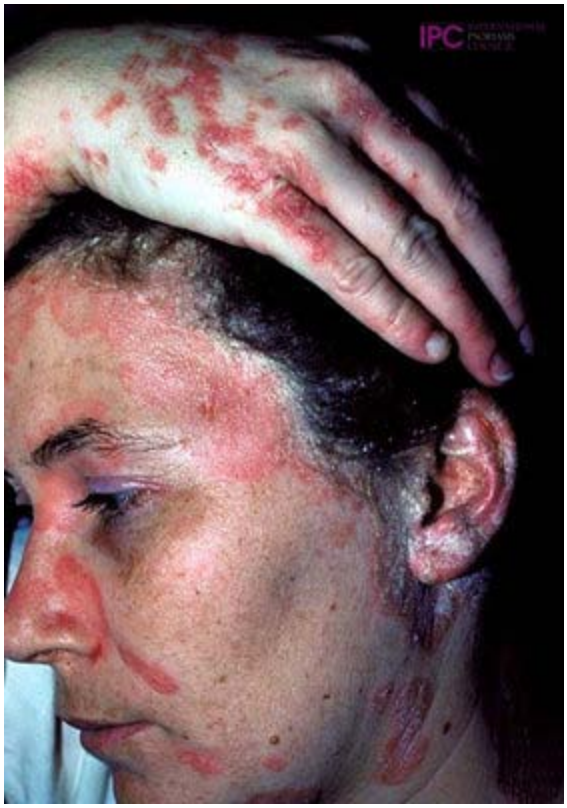
Psoriasis has widespread effects on patients and their families. The psychological impact of the disease, including feelings of stigmatization, isolation, anxiety and depression, can have an even greater impact on patients' everyday lives than do the physical symptoms.[9] In Canada, the rate of associated medical and psychological problems is reported to be up to 4-fold higher than in the general population. One-third of Canadians with psoriasis describe

[7] Levy, A. R., et al. Economic burden of moderate to severe plaque psoriasis in Canada. *International Journal of Dermatology*, 51 (2012): 1432–1440.

[8] Gupta, Ashok Kumar, et al. Effectiveness of Conventional Drug Therapy of Plaque Psoriasis in the Context of Consensus Guidelines: A Prospective Observational Study in 150 Patients. *Annals of Dermatology* 25.2 (2013): 156-162.

[9] Bewley, A., et al. Psychosocial and symptomatic burden of psoriasis for patients in Europe, the USA and Canada. *Abstract presented at: EADV Congress, Prague*. 2012.

their disease as a substantial problem in their daily life.[10] Also, patients report reduced income and increased unemployment, at levels that increase with psoriasis severity.[11]



The scope of the problem is so large that in 2014, it was formally recognized by the World Health Organization as a "chronic, non-communicable, painful, disfiguring, and disabling disease for which there is no cure " and the WHO stressed the importance of all member states to "continue addressing key risk factors for non-communicable diseases through the implementation of the WHO global action plan for the prevention and control of non-communicable diseases 2013–2020".

Within the context of psoriasis, and "underscoring that those with psoriasis are at an elevated risk for a number of co-morbid conditions, namely, cardiovascular diseases, diabetes, obesity, Crohn's disease, heart attack, ulcerative colitis, metabolic syndrome, stroke and liver disease" and that "up to 42% of those with psoriasis also develop psoriatic arthritis, which causes pain, stiffness and swelling at the joints and can lead to permanent disfigurement and disability, the resolution further speaks to "the urgent need to promote and improve human health, **providing access to treatment** (*emphasis ours*) and health care education."

Canadian research shows that the economic burden of psoriasis is high in this country. The total annual cost of moderate-to-severe psoriasis has been estimated at $1.7 billion in direct

[10] Lynde, C.W., et al. The burden of psoriasis in Canada: insights from the pSoriasis Knowledge IN Canada (SKIN) survey. *J Cutan Med Surg*. 13.5 (2009):235-52.

[11] Mahler, R., et al. The burden of psoriasis and barriers to satisfactory care: results from a Canadian patient survey. *J Cutan Med Surg.* 13.6 (2009):283-93.

costs and lost productivity.[12] Psoriasis treatment costs more than $30 million annually for phototherapy treatments alone.[13]

Between 10 and 30 per cent of psoriasis sufferers develop psoriatic arthritis, a chronic inflammation of the joints causing pain and other symptoms such as fatigue, anemia and mood changes. When diagnosed early and treated appropriately with medication, surgery (in some cases), exercise, rest and joint protection, severe damage to the joints can be avoided. Scans also reveal that psoriasis patients have inflammation in the aorta, liver and joints. [14]In addition they experience a higher than normal incidence of obesity, heart disease, diabetes, metabolic syndrome and kidney disease.

The importance of treating this disease cannot be questioned.

The World Health Organization Resolution on Psoriasis— 67.9

The scope of the problem for people living with Psoriasis so large that in 2014, it was formally recognized by the World Health Organization (WHO) as a "chronic, non-communicable, painful, disfiguring, and disabling disease for which there is no cure. " The WHO stressed the importance of all member states to "continue addressing key risk factors for non-communicable diseases through the implementation of the WHO global action plan for the prevention and control of non-communicable diseases 2013–2020"; Within the context of psoriasis, and " underscoring that those with psoriasis are at an elevated risk for a number of co-morbid conditions, namely, cardiovascular diseases, diabetes, obesity, Crohn's disease, heart attack, ulcerative colitis, metabolic syndrome, stroke and liver disease" and that "up to 42% of those with psoriasis also develop psoriatic arthritis, which causes pain, stiffness and swelling at the joints and can lead to permanent disfigurement and disability, the resolution further speaks to the urgent

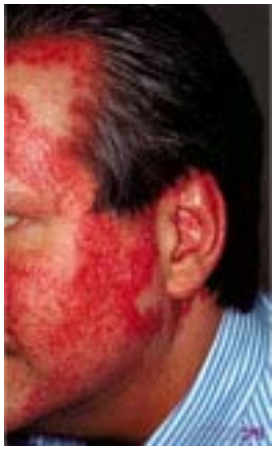
[12] Levy, A. R., et al. Economic burden of moderate to severe plaque psoriasis in Canada. *International Journal of Dermatology*, 51 (2012): 1432–1440.

[13] Medical Advisory Secretariat. Ultraviolet phototherapy management of moderate-to-severe plaque psoriasis: an evidence-based analysis. *Ontario Health Technology Assessment Series* 9.27 (2009)

[14]Archives of Dermatology. Systemic and Vascular Inflammation in Patients with Moderate to Severe psoriasis – September, 2011

need to promote and improve human health, **providing access to treatment** (*emphasis ours*) and health care education."

The promise of medical procedures and treatments



An expanding array of treatment options is available in Canada. Upon diagnosis, psoriasis patients are offered a stepwise approach to treatment. For milder cases, topical treatments such as corticosteroids, emollients, vitamins A and D, combination therapies with calcipotriol plus betamethasone, dithranol (anthralin) and calcineurin inhibitors (tacrolimus and pimecrolimus) may be effective. Should these options prove ineffective, more potent ingested drug therapies may be tried, such as methotrexate, cyclosporine or tazarotene. Light therapy may also be prescribed: UVA and/or UVB (narrow band or broad band). Moderate to severe cases may need treatment with biological agents, such as infliximab (brand name Remicade), etanercept (Enbrel), adalimumab (Humira) or ustekinumab (Stelara).[15]

Similarly, a stepwise approach is taken for the treatment of psoriatic arthritis. It is recommended that patients try a non-steroidal anti-inflammatory drug (NSAID) and/or a corticosteroid before moving on to a disease-modifying agent such as gold, methotrexate or cyclosporine. Should these agents prove ineffective, many of the same biological agents used to treat psoriasis are also used for psoriatic arthritis.

Phototherapy

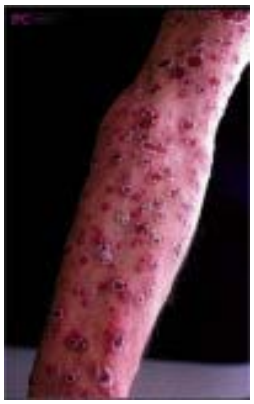
Phototherapy is the mainstay of medical procedures to treat psoriasis. Ultraviolet B (broad or narrow band) is the most popular form of light therapy. This treatment may be administered in a hospital, private clinic or at home and is given several times a week. Provincial health insurance covers the cost of hospital- or clinic-based treatments but does not fund home-based UVB equipment.

[15] Medical Advisory Secretariat. Ultraviolet phototherapy management of moderate-to-severe plaque psoriasis: an evidence-based analysis. *Ontario Health Technology Assessment Series* 9.27 (2009)

This form of treatment appears to be underutilized. A recent survey of psoriasis patients across Canada showed that phototherapy had been used by only 38 per cent of respondents and was currently used by only 7 per cent.[16] It is likely that the low utilization rate is due to phototherapy facilities being unavailable or inconvenient. In recent years, many hospitals and private clinics have closed due to low levels of support from governments.

Home UVB therapy has been shown to be cost effective[17,18] and is recommended as a primary treatment option for eligible patients. Device costs for a panel unit of 10 bulbs for home use is about $2,900 and the replacement cost for individual bulbs amounts to about $120 each.[19] While this is a large cost for patients to bear, it is a more cost effective alternative for governments than funding private or hospital phototherapy clinics.

Drug treatments



When prescribed and taken according to clinical guidelines, drugs have been shown to be effective treatments for psoriasis[20] and psoriatic arthritis. Because these diseases are usually treated on an outpatient basis, the costs of prescribed drugs are the responsibility of the patient. Over half of Canadians have private coverage for prescription drugs, most often through their employers. Almost all other Canadians are covered by a provincial, territorial or federal drug program.

While biological drugs have been shown to be particularly effective in the treatment of moderate to severe psoriasis,[21] due to their higher cost this class of medications is usually approved for use by drug plans only when: a) the psoriasis is sufficiently severe, as measured by the PASI (Psoriasis Area and Severity Index)

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[16] Poulin, Y., et al. A Canadian online survey to evaluate awareness and treatment satisfaction in individuals with moderate to severe plaque psoriasis. *International Journal of Dermatology*, 49 (2010): 1368–1375.

[17] Medical Advisory Secretariat. Ultraviolet phototherapy management of moderate-to-severe plaque psoriasis: an evidence-based analysis. *Ontario Health Technology Assessment Series* 9.27 (2009)

[18] Koek, Mayke BG, et al. Cost effectiveness of home ultraviolet B phototherapy for psoriasis: economic evaluation of a randomised controlled trial (PLUTO study). *BMJ: British Medical Journal* 340 (2010).

[19] Medical Advisory Secretariat. Ultraviolet phototherapy management of moderate-to-severe plaque psoriasis: an evidence-based analysis. *Ontario Health Technology Assessment Series* 9.27 (2009)

[20] Gupta, Ashok Kumar, et al. Effectiveness of Conventional Drug Therapy of Plaque Psoriasis in the Context of Consensus Guidelines: A Prospective Observational Study in 150 Patients. *Annals of Dermatology* 25.2 (2013): 156-162.

[21] Weger, Wolfgang. Current status and new developments in the treatment of psoriasis and psoriatic arthritis with biological agents. *British Journal of Pharmacology* 160.4 (2010): 810-820.

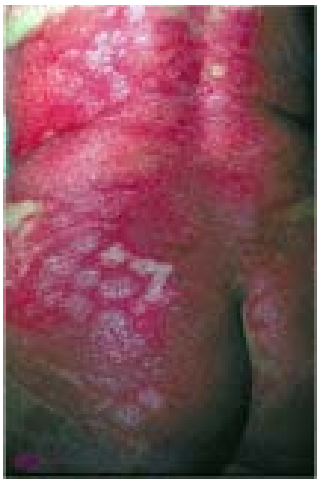
score; b) the patient has tried and failed on 1 or 2 drugs from the second level (e.g., cyclosporine and/or methotrexate); and c) after the patient has tried and failed on ultraviolet light therapy. Similarly for psoriatic arthritis, patients must have severe disease, and have tried and failed on non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids and disease-modifying drugs.

There are concerns with this stepped approach. Second-level drugs (such as methotrexate and cyclosporine) have significant toxicities and, because psoriasis is a chronic systemic condition and is associated with other medical conditions such as depression, obesity, diabetes, heart disease and stroke, there is increased risk to patients.

More than 20 clinical trials are currently ongoing around the world of new drugs and indications related to psoriasis and psoriatic arthritis. While these new treatments are urgently needed, patients fear that increasingly narrow criteria will further restrict access to these therapeutic advances.

Emerging issues for psoriasis patients

Two issues are of growing concern to psoriasis patients: the changing environment of private health benefits plans and subsequent entry biological drugs. This section provides a brief overview of each topic.



The changing private insurance environment

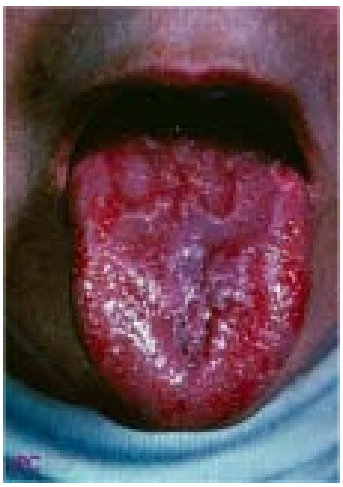
How private insurance works

As drug plans are chosen by and paid for by the employer and administered by their insurance company, employers choose a plan based on affordability, the needs of their employees and drug plans offered by competitors (i.e., other employers who compete for similar employees). There is a broad range of drug plans and coverage features that employers can choose to offer their employees. Once an employer chooses the drug plan design, they ask for bids from several different insurance companies and select an insurance carrier to administer their plan.

The insurance company sets up an insurance contract that formalizes the drug plan design and rates that the employer will pay for the coverage. Every year the employer and insurer go through a renewal process where the insurer determines what the premiums should be

for the next year based on the amount paid for drugs over the previous year and what they predict will change in the upcoming year.

Emerging trends



New specialty and biological drugs offer outstanding treatment for many conditions; however their price tags are driving up private drug plan costs. In 2012, 44 per cent of employer-paid private drug plans saw their premiums increase;[22] while specialty drugs represented 22 per cent of private drug plan spending they comprised only 1.2 per cent of the number of claims. The average cost for a private plan specialty prescription was $1,240 versus $46 for all other drugs.

This trend to escalating costs is emerging as an important issue for employers who sponsor drug benefit plans. Specialty medications represented 55 per cent of new drug approvals and 64 per cent of drugs in development and are estimated to be 25 to 30 per cent of private drug plan spending in 2017.[23]

In order to manage growing drug plan costs, private payers are implementing a variety of plan designs to manage specialty drug use:

1. **Special or prior authorization** requires a patient or their physician to submit additional information for the insurance carrier to review to ensure the patient meets specific criteria before coverage can be confirmed. The review could include clinical information, prior treatments and/or diagnosis.
2. **Case management** is similar to special or prior authorization but requires much more information to be provided to the insurance company's case manager who will review the treatment plan and consult with the physician. Case managers may recommend an alternate treatment or monitor the patient to ensure that they obtain the best possible outcomes.
3. **Preferred pharmacies** are being used by private plans to lower costs through economies of scale. Some payers require patients to use a pharmacy or chain exclusively, and others offer a higher reimbursement for patients who use the preferred

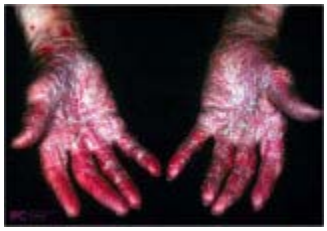
[22] Group Benefits Prescription Drug Outlook

[23] Express Scripts Canada 2012 Drug Trend Report

pharmacy. Some insurers have partnered with specialty pharmacies for exclusive distribution of biologic treatments to patients.

4. **Managed formularies:** Some employers feel they can no longer afford to cover all drugs, so they choose managed formularies where their drug plans pay only for a selection of effective and affordable drugs. Their insurance carrier or pharmacy benefit manager will manage the formulary on behalf the employer.

Requesting an employer exception

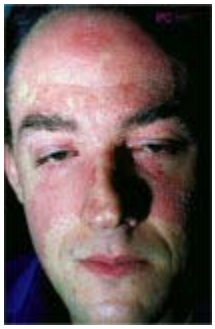


If an insurance carrier refuses to cover a drug, an employee can ask their employer for an exception. When the insurance carrier says a drug is not covered, it is usually because the particular insurance plan chosen by the employer does not cover the drug. The insurance carrier is following the terms of the insurance contract chosen by the employer. Because the employer chose the plan, they may have the opportunity to ask the insurer to pay for a drug that is not covered by the drug plan. This is called an "exception" or "extra-contractual coverage"

Any exceptions have to be agreed upon by both the insurer and the plan sponsor and there is the potential that this could affect the price of the whole insurance plan. In order to accommodate a special request, the employer and insurer will have to look at the financials of the drug plan and determine if additional premiums are needed to accommodate a claim for a drug that was not included in the initial plan set-up and premium calculation.

The ability to request or negotiate exceptions depends a lot on the size of the employer and the financial arrangements with the insurance company. Large employers often have a lot more flexibility to negotiate an exception with their insurance carriers, although they may not have the budget or wish to set a precedent. In the end, each request is handled on a case-by-case basis and reviewed against the terms of the contract in place.

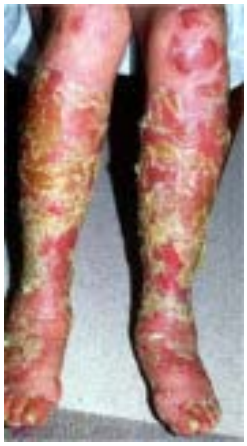
Subsequent-entry biological drugs



Another emerging issue for psoriasis patients is the introduction of subsequent-entry biological drugs (SEBs). These are close, but not exact, copies of biological drugs whose patents have expired. A SEB can be approved for sale in Canada based on a reduced requirement for regulatory data, compared to a customary New Drug Submission data package. Because they don't need to invest in as many expensive studies, manufacturers are expected to be able to sell the drug at a somewhat reduced price. Patients benefit from a greater range of choice and from

lower costs. However, the introduction of an SEB is not without some risks to patients.

Differences between SEBs and generic drugs



Biological drugs, as the name suggests, are different than traditional medications which are chemically-synthesized small molecules. A generic copy of a regular, synthesized drug is considered to be identical to the original in terms of its clinical effects. In contrast, biological medications are manufactured by living cells and are hundreds or even thousands of times larger than a synthetic drug. Because cellular production creates small but measurable differences in the molecular structure, a copy of a biological drug will not be identical. To recognize this distinction, copies of biological drugs are termed 'subsequent-entry biologics' (SEBs) by Health Canada, the body that approves drugs for marketing. (The terms 'biosimilars' or 'follow-on biologics' are used elsewhere in the world.)

To obtain approval from Health Canada, a generic drug must be shown to be chemically identical to the original. The manufacturer can then reference the originator's submission and the drug can be marketed for all approved indications, or clinical uses. In contrast, a SEB manufacturer must provide extensive data demonstrating *similarity* with the reference biologic drug, and also may be required to generate original non-clinical and clinical information. The number of studies requested is tailored to a particular class of products or a specific case.

Table 1. How SEBs differ from generic drugs

Comparison to original drug	Generic	Subsequent-Entry Biologic (SEB)
Chemical structure	Active ingredient is chemically identical (non-medicinal ingredients may differ)	Not chemically identical
Pharmacological effect	Within predefined pharmacokinetic parameters*	Varies by drug and manufacturer
Clinical effect	Same as original	Varies by drug and manufacturer

Comparison to original drug	Generic	Subsequent-Entry Biologic (SEB)
Indications	Same as original	Must apply for indications separately
Interchangeability	Interchangeable	Not automatically interchangeable

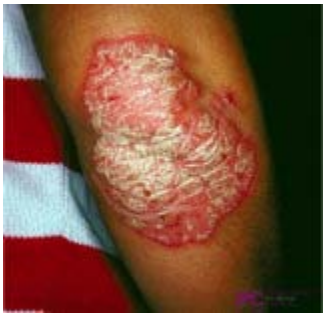
* Pharmacokinetic parameters describe the drug's speed of absorption into the bloodstream, its elimination from the body and its peak concentration in the blood. The pharmacokinetic profile of a generic medication must be within a 20 per cent variation of the original drug.

Not interchangeable

Because a SEB is chemically different from the original drug, it may have somewhat different effects in the body. Unlike generic drugs, SEBs are not automatically deemed to be interchangeable with the original biological drug and are licensed only for the indications included in their submission.

Currently in Canada, drug plan managers do not automatically interchange a SEB for another biological drug, although it is within their power to do so. When a health professional writes a prescription for a specific brand name biological drug, it is not substituted at the pharmacy for a cheaper SEB version (as is done in some other jurisdictions). As more SEBs enter the market, however, there may be more pressures to save costs by mandating therapeutic substitution.

SEBs do not offer the same level of savings as traditional generics. Generic medications can be sold at a small fraction of the brand name price because the company's costs are limited to manufacturing and distribution. In contrast, not only must a SEB manufacturer conduct additional studies to obtain approval, cellular manufacturing processes are highly complex and very costly. For these reasons, SEBs will typically sell at only a modest discount to the originator's price.



Patients' concerns about SEBs

While patients (and insurance and government payers) benefit from the wider choices and cost savings from SEBs, there remain several concerns. Doctors may feel pressured to switch patients to a cheaper SEB without understanding the differences. For example, a

patient who is responding to an original biological drug may not achieve the same results on a SEB. Furthermore, because there is a relatively high rate of medication fatigue that psoriasis and psoriatic arthritis patients encounter wherein their bodies develop a tolerance for a medication, requiring a change to another different agent is crucial to tackle the often-devastating symptoms and co-morbidities. CAPP urges all payers to keep this important aspect in mind and approve new treatments for reimbursement as they become available. In some cases, the SEB may not be approved for the same uses as the original drug. Without reviewing the product monograph, the prescribing doctor may not be aware of these distinctions.

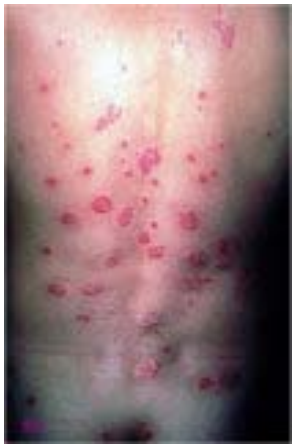
Over the coming years as more SEBs come onto the market in Canada, patients and prescribers need to be aware of the risks as well as the benefits of these new entities.

New treatments in the pipeline

CAPP is aware of several new innovative treatments for patients in the pipeline. Because there is a relatively high rate of medication fatigue that psoriasis and psoriatic arthritis patients encounter wherein their bodies develop a tolerance for a medication, requiring a change to another different agent to tackle the often-devastating symptoms and co-morbidities.

Today's challenges

Many challenges remain in accessing effective medical procedures and treatments for psoriasis.



- Most psoriasis patients must **wait several months for a routine appointment** to see a dermatologist, reflecting a significant shortage of dermatologists, especially outside urban centres. Canadians who live in rural areas have little or no access to dermatological care, and many jurisdictions appear not to have planned to replace the 20 per cent of dermatologists who expect to retire in the next 5 years.
- There is a critical and growing **shortage of phototherapy clinics**, resulting in patients going without effective treatments and placing an unnecessary burden on drug budgets for expensive biological therapies, which are the only alternative. Further, home phototherapy, an inexpensive alternative, is typically not covered by either government or some private insurance plans.

- New medications are being introduced every year which can be more effective but are usually more costly than existing therapies. Public drug programs are **slow to cover new drugs** and often impose **arduous restrictions** or deny funding.

CAPP recognizes that governments cannot afford to fund all available treatments, nor can the numbers of dermatologists be increased quickly with ease. CAPP's position on these issues reflects the premise of the *Canada Health Act* which promises "reasonable access to health services without financial or other barriers". In this Report Card, the approach to defining reasonable access gives priority to the needs of the patient and measures access goals against standards of care, as measured by accepted benchmarks.

About CAPP

The Canadian Association of Psoriasis Patients (CAPP) is a federally incorporated, non-profit patient support organization founded to serve the unique needs of Canadian psoriasis and psoriatic arthritis patients and their families. It is a subsidiary of the Canadian Skin Patient Alliance (CSPA), also a federally incorporated, non-profit patient support organization.

CAPP ACPP
Canadian Association of Psoriasis Patients
Association canadienne des patients atteints de psoriasis

Our goal is to get this challenging and misunderstood skin condition out into the open, and to help us all as we manage our lives with psoriasis and psoriatic arthritis. We also want to make sure that anyone, anywhere in Canada can get access to the treatment they need.

CAPP's positions on reasonable access to care and treatments

Positions of the Canadian Association of Psoriasis Patients:

1. Psoriasis patients should have access to dermatological care within an acceptable wait time regardless of where they live in Canada. We believe that Canadians seeking treatment for psoriasis and psoriatic arthritis should not have to wait longer than 5 weeks to see a dermatologist—the national median wait time reported in 2001.
2. While we recognize that it is not possible for all dermatology services to be available within commuting distance of all Canadians, we believe that phototherapy—a mainstay of treatment for psoriasis—should be available to every Canadian, either in a clinic or as an insured service at home for those who cannot access a clinic.
3. All drugs that are considered the standard of care should be funded without restrictions. Dermatologists need access to the broadest range of medication options. A drug treatment that works for one patient may not work for another. In many chronic skin diseases, the body can build up a tolerance to a 'tried and true' medication over time and thus new ones need to be available. Also, some psoriasis patients are particularly susceptible to side effects of drugs and to drug-drug interactions. Since psoriasis and psoriatic arthritis are chronic conditions, a patient's quality of life can be dramatically affected by drugs that are poorly tolerated, less effective or that require them to go to unreasonable lengths to administer.

About the Report Card

This Report Card was developed to give voice to the rising concerns of the million Canadians who suffer from psoriasis and psoriatic arthritis about the unacceptably low and, in many areas, deteriorating availability of dermatological care and treatment that they receive through the publicly funded health system. At the same time, it also offers an opportunity to recognize the efforts made by governments and dermatologists to improve the system.

The Report Card covers 3 main areas:

1. Access to dermatological care
2. Access to phototherapy
3. Access to medications

The content of the Report Card has been reviewed for accuracy by an expert panel of dermatologists.

Figure 1. Data Sources

Access to dermatological care	***Wait times: Canadian Skin Patient Alliance survey 2011*** ***Full-time dermatologists: Analysis of 2011-12 provincial billing data (courtesy of Dr. Evert Tuyp)*** ***Fee schedules: Provincial physicians' agreements (courtesy of Dr. Evert Tuyp)***
Access to phototherapy	*Numbers of phototherapy clinics: provided by the CSPA Medical Advisory Board.*
Access to medications	*Provincial, territorial and NIHB formularies: accessed online, effective January 31st, 2014.*

How performance was graded

Grades were decided by CAPP based on our perspectives, on clinical practice guidelines and, where the latter do not exist, on historical precedent and on the judgement of a panel of dermatologists of what constitutes an acceptable standard of care, as provided to the Canadian Skin Patient Alliance (CSPA) for its *Skin Deep* Report Card in 2012.

At this time there are no published benchmarks that define the point at which psoriasis or psoriatic arthritis patients experience harm from lack of access to dermatological care and treatment. The benchmarks described in the table below were obtained from published, historical, calculated or best practice sources where possible. An algorithm was used to establish grades in each section of the Report Card, as follows.

Grading

1. Performance measures within each section were assigned the following weights:

Excel	5 points
Pass	4 points
Needs improvement	2 points
Fail	0 points

2. In each section, the ratio of total points to total available points was calculated.

3. The overall grade was assigned and colour-coded based on the following ranges:

Excel	>75%
Pass	51-75%
Needs improvement	35-50%
Fail	<35%

The following scoring metrics were used:

Table 2. Scoring Metrics

Section	Measure	Performance benchmark *(source)*	Scoring metrics
Access to dermatological care	Wait time for non-urgent consultation	5 weeks *(CDA workforce survey 2001 national median wait time)*	Excel: < 5 weeks Pass: 5-6 weeks Needs improvement: 7-12 weeks Fail: > 12 weeks
	Ratio of full-time dermatologists to population	1:62,500[24] *(National Specialty Review. Royal College of Physicians & Surgeons of Canada. 1988)*	Excel: > 1:62,500 Pass: 1:62,501 to 1:70,000 Needs improvement: 1:70,001 to 1:80,000 Fail: < 1:80,000
Access to phototherapy	Number of phototherapy facilities per population	Ratio of 1 phototherapy facility per 62,500 population *(National Specialty Review. Royal College of Physicians & Surgeons of Canada. 1988)*	Excel: > 1:62,500 Pass: 1:62,500 to 1:70,000 Needs improvement: 1:70,001 to 1:80,000 Fail: < 1:80,000
	Home phototherapy as an insured service	Provincial and territorial lists of insured services *(CAPP standard)*	Pass: Insured service for all eligible residents Needs improvement: Insured service with restrictions Fail: Not an insured service
Access to medications	Number of recommended psoriasis drugs on formulary	All drugs deemed the standard of care are on formulary *(CAPP standard)* NB: Lower "pass" rate reflects time needed to review new drugs.	Pass: 90% or more drugs on formulary Needs improvement: 60-89% Fail: < 60%
	Restrictions on use of psoriasis drugs	Number of funded drugs having no restrictions *(CAPP standard)* NB: Lower "pass" rate reflects restrictions for reasons of patient safety	Excel: > 90% unrestricted Pass: 80-89% Needs improvement: 60-79% Fail: < 60%

[24] The ratio of population-to-dermatologist recommended by the Royal College of Physicians & Surgeons of Canada is 1:62,500. This figure recognizes a shortfall in the number of dermatologists when the original calculation was conducted in 1988 and is therefore more accurate than the original 1:65,000 benchmark used in the *Skin Deep* report by the Canadian Skin Patient Alliance, 2012.

How is Canada Performing?

	Access to Dermatological Care	Access to Phototherapy	Access to Medications
Canada	Needs improvement	Fail	Fail
British Columbia	Fail	Fail	Fail
Alberta	Pass	Fail	Needs improvement
Saskatchewan	Fail	Fail	Needs improvement
Manitoba	Needs improvement	Fail	Needs improvement
Ontario	Needs improvement	Fail	Fail
Quebec	Pass	Fail	Needs improvement
New Brunswick	Fail	Needs improvement	Fail
Prince Edward Island	Fail	Fail	Fail
Nova Scotia	Needs improvement	Fail	Fail
Newfoundland & Labrador	Needs improvement	Fail	Fail
Yukon	Fail	Fail	Fail
Northwest Territories	Needs improvement	Needs improvement	Fail
Nunavut	Fail	Fail	Fail
Non-Insured Health Benefit (NIHB) program	Not applicable	Fail	Fail

Table 3. How is Canada Performing?

Key issues

1. Lack of access to dermatological care

Access to dermatologists is vitally important for Canadians living with psoriasis and psoriatic arthritis. While primary care providers are able to treat milder cases of psoriasis, the *Canadian Guidelines for the Management of Plaque Psoriasis*[25] recommend that patients are referred to a specialist when the disease is "extensive, distressing, or unresponsive, or where the patient requires in-depth counselling or education outside the scope of a primary care practice."

As a whole, Canada receives a 'needs improvement' grade for access to dermatological care. This score reflects both the wait times that patients experience accessing a dermatologist and the ratio of dermatologists to population.

Table 4. Overall performance ratings on access to dermatological care

CDN	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL	YT	NT	NU
NI	Fail	Pass	Fail	NI	NI	Pass	Fail	Fail	NI	NI	Fail	Pass	Fail

Legend: NI = needs improvement

Long wait times

Unfortunately, across Canada many patients with moderate to severe psoriasis wait an unacceptably long time for a specialist consultation after they have been referred by their family doctor. Canadians living outside major cities are particularly disadvantaged because they must travel long distances to access specialist care.

The benchmark for wait times is 5 weeks for an initial, non-urgent consultation with a dermatologist. This measure was chosen to reflect the need for patients with debilitating conditions to obtain timely treatment which may allow them to return to their daily lives without detrimental effects to their health, work, psychological state and

[25] *Canadian Guidelines for the Management of Plaque Psoriasis*, June 2009.

social functioning. This benchmark is based on the national median wait time reported by the Canadian Dermatology Association's Workforce Survey in 2001.

An independent survey conducted in February-March 2011, sponsored by the Canadian Skin Patient Alliance (CSPA), showed that patients wait a median of 12 weeks, meaning that half of patients must wait 3 months or longer for an initial appointment. One-quarter of patients wait 23 weeks—nearly 6 months—to be seen. None of the provinces comes close to reaching the 5 week benchmark.

Table 5 . Wait times for a non-urgent dermatologist appointment

	Bmk	CDN	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL
Median wait time (weeks) for routine consult	5	12	10	8	14*	14*	12	18	23*	n/a	23*	23*

* Wait times data for Saskatchewan and Manitoba and for the Atlantic Provinces were combined, due to the small number of responses in each individual province.

Legend: *Bmk = benchmark* *White = pass* *Blue = needs improvement* *Red = fail*

Physicians themselves concur with the CSPA's findings that there is a lack of access to dermatologists. In fact, Canadian dermatologists report that they are nearly twice as difficult to access compared to other specialists. In the 2010 National Physician Survey,[26] doctors were asked to rate their own accessibility, on behalf of their patients. Thirty-eight per cent of dermatologists said that their accessibility was either 'poor' or 'fair' whereas only 20 per cent of doctors rated access to all specialists combined (including cardiologists, neurologists, surgeons and others) as being 'poor' or 'fair'. In all provinces surveyed, dermatologists were considerably more difficult to see.

To make matters worse, wait times have been rising progressively, as shown in the chart below. The chart compares 3 surveys conducted over the past decade against the CSPA benchmark median wait time of 5 weeks (red line). (The term median means that half of patients had to wait longer than the median and half waited a shorter time.)

[26] 2010 National Physician Survey. The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada.

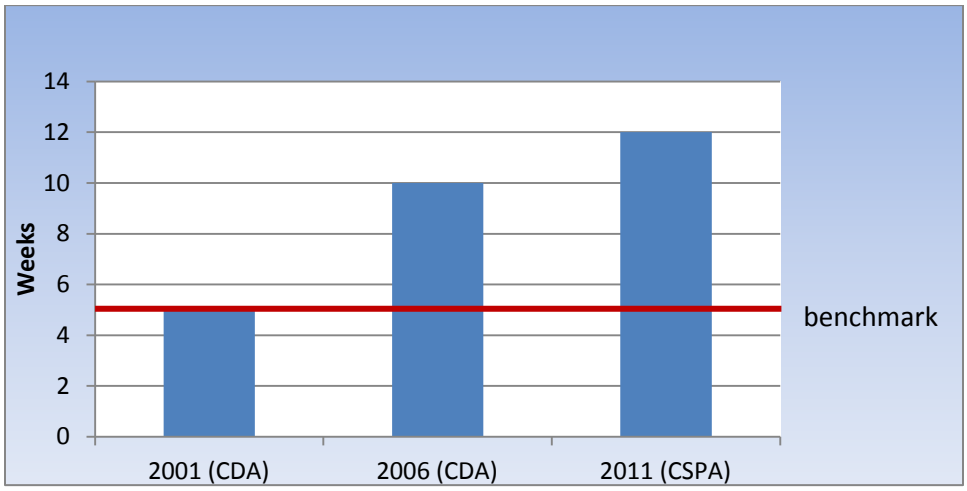


Figure 2. Median Wait Times for Dermatologist Consultation

The Canadian Dermatology Association (CDA) 2001 Workforce Survey reported a national median wait time of 5 weeks for a routine dermatologist appointment. In 2006, the CDA reported that wait times had doubled to 10 weeks. The 2011 CSPA survey showed that wait times had further increased to 12 weeks. Although caution should be used in comparing data from different sources, the trend toward worsening wait times is clear. (The trend may actually be understated. The CDA survey examined time to the third-next appointment whereas the CSPA survey measured time to the next available appointment.)

Low and falling numbers of dermatologists

One reason for long wait times may be the shortage of dermatologists. The benchmark ratio of 1 medical dermatologist per 62,500 population was chosen based on the recommendations from the Royal College of Physicians and Surgeons of Canada.[27] As a whole, Canada has only 1 full-time, medical dermatologist for every 67,400 population. This number is illusory because it does not reflect the drastic shortage in non-urban areas.

In 8 of 10 provinces, the number of full-time dermatologists is insufficient to achieve the benchmark. In fact, in Saskatchewan, 1 dermatologist provides services to over 217,500 people. (Quebec's inconsistency with this pattern remains unexplained: while its 1:53,500 ratio of dermatologists to population is the second-highest of all provinces, patients wait an

[27] Royal College of Physicians and Surgeons of Canada. *National Specialty Physician Review*. July 1988.

unexpectedly long 18 weeks for a consultation – the second longest wait time in the country.)

Although the number of full-time, medical dermatologists has increased over the past 2 years, as shown in the chart below, in most provinces their numbers remain short of requirements.

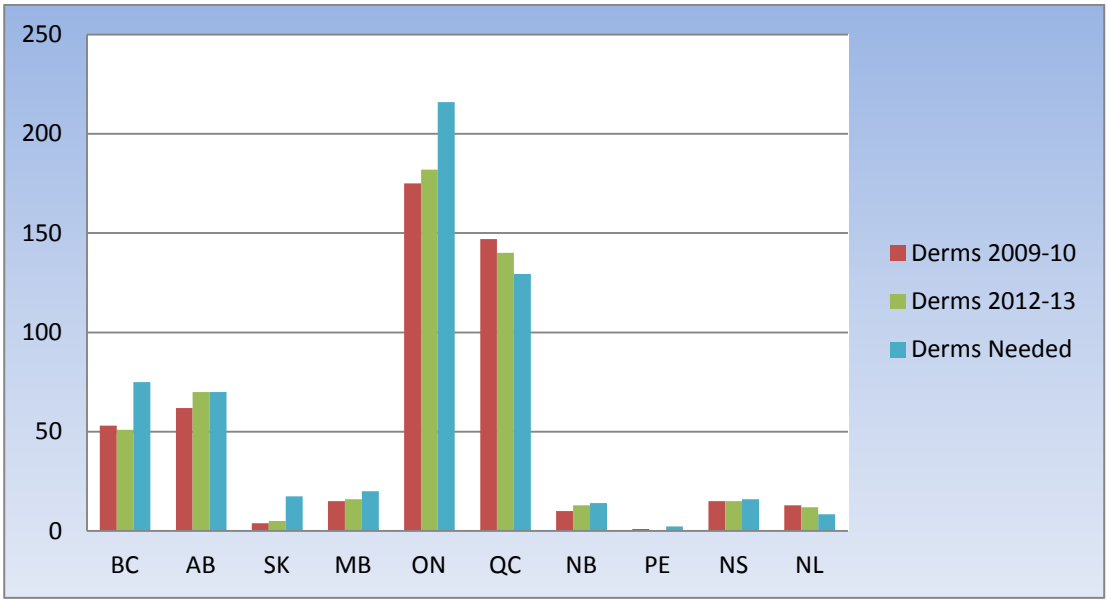


Figure 3. Change in Number of Dermatologists 2009/10-2012/13

There are 23 more full-time, medical dermatologists in practice today than there were 2 years ago – a rate of increase that somewhat exceeds population growth. As a result, 2 more provinces now have adequate numbers of dermatologists to serve their populations than was the case in 2009-10. However, this does not guarantee access to dermatological care since wait times in all provinces remain longer than the average of 5 weeks experienced in 2001. Also, dermatologists are located in urban areas, leaving rural populations without reasonable access.

Lack of access in rural and remote areas

The shortage of dermatologists is even more acute in rural and remote areas of Canada. As shown in the map below, the concentration of dermatologists is largely in southern, urban areas. No dermatologists are based in Yukon, Nunavut or in the northern parts of most provinces. (One dermatologist now practices in Northwest Territories.)

Figure 4. Map: Distribution of Dermatologists in Canada 2004

Source: "Geographic Distribution of Physicians in Canada: Beyond How Many and Where". Canadian Institute for Health Information (CIHI) 2005.

> *While there are now a large number of dermatology residents at the University of Toronto, there is no mechanism in place to incent them to practise outside of the major metropolitan areas."*
>
> *— Dr. Charles Lynde, dermatologist, Markham, Ontario*

Although many dermatologists provide outreach services to smaller communities, the chart *(Fig 5, next page)* shows the discrepancy between the population residing outside urban centres and the level of outreach provided. According to the 2006 census, 20 per cent of Canadians reside in a rural or remote area (red bar). However, only 8 per cent of dermatologists' time is spent practising outside urban areas (blue bar), according to the Canadian Dermatology Association's 2006 Workforce Survey. This means that a Canadian living in a rural or remote community receives less than half the time a dermatologist would spend with someone living in an urban area.

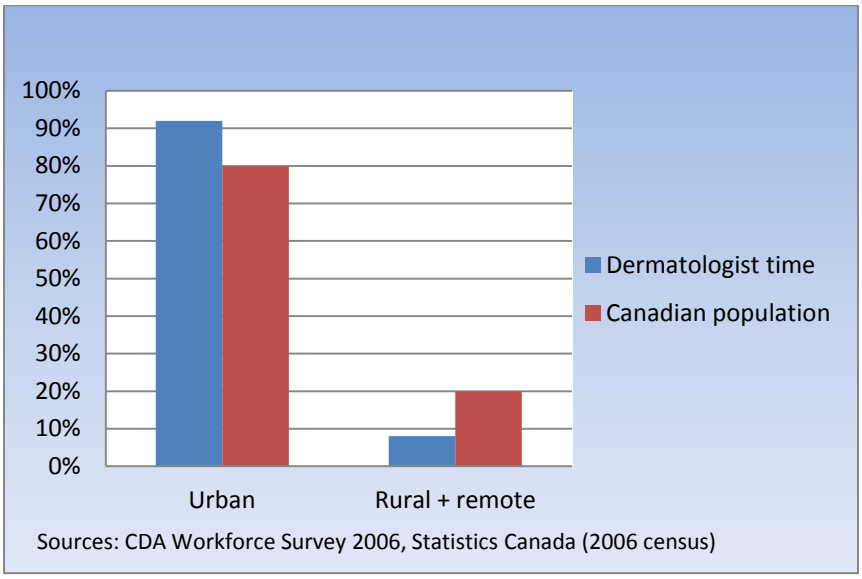


Figure 5. Urban concentration of dermatology practice

Need to train more dermatologists

In addition to current low numbers of dermatologists in many areas across Canada, a major concern is that the number of dermatologists being trained will not keep up with expected retirements and increased demand for services in future. The average age of dermatologists in Canada is 55 — tied with psychiatry for being the oldest of all medical specialities.[28] More than 1 in 5 is already over age 65.[29]

The number of full-time-equivalent dermatologists needs to increase at an annual rate of 6.2 per cent in order to replace retirees and to meet future demands for services due to growth in the population and rising incidences of skin diseases. Canada has done some catching up in this regard over the past 3 years. In the 5 year period ending in 2008-09, the number of full-time dermatologists had risen at a rate of only 0.8 per cent annually[30] —far from the needed rate of growth. By 2011-12, this figure had risen to 5.6 per cent — a rate of increase approaching the target.

[28] CMA Master file, January 2013. Canadian Medical Association.

[29] Canadian Medical Association 2010.

[30] National Physicians Database 2004-05 to 2008-09.

Need for more dermatology health professionals

Long wait times for dermatological care could be alleviated by employing other health professionals, such as dermatology nurses and physician assistants, to work alongside dermatologists.

Physician assistants are widely used in the U.S. but to a much more limited extent in Canada. Although physician assistants were first introduced in the Canadian Armed Forces in the 1970s, they were first introduced into civilian practice in Manitoba in 1999, Ontario in 2007 and in 2013 in Alberta.[31] The lack of enabling legislation and/or regulation across all provinces has restricted the uptake of this form of assistance for dermatologists and other physicians.

Certified dermatology nurses are being used effectively in other countries to assist busy dermatologists, by seeing and screening patients and by overseeing treatments. The table below shows that, on average, 1 dermatology nurse is employed for every 5 dermatologists in Canada. In the United Kingdom, there are 4 dermatology nurses or dermatology nurse practitioners for every 5 dermatologists, reflecting a team-based approached to providing care.[32] In the U.S., 30 per cent of dermatologists said they used a dermatology nurse or a dermatology nurse practitioner in their practices.[33] The CAPP benchmark ratio of 0.5

Table 6. Ratios of dermatology nurses to dermatologists

Benchmark	Canada	U.K.	U.S.
0.5	0.2	0.8	0.3

[31] Born, Karen, et al. Integrating Physician Assistants in Canada. *Healthy Debate*. December 5, 2013.

[32] British Association of Dermatologists and the Royal College of Physicians and Surgeons 2008. *An audit of the provision of dermatology services in secondary care in the United Kingdom with a focus on the care of people with psoriasis*.

[33] Resneck, J.S. Jr., et al. Who else is providing care in dermatology practices? Trends in the use of nonphysician clinicians. *Journal of the American Academy of Dermatology* Volume 58, Issue 2, February 2008, Pages 211-216.

Nova Scotia leads the country in its employment of dermatology nurses whereas Quebec and Newfoundland & Labrador lag. (Prince Edward Island currently has no dermatologist and so may not be able to support a dermatology nurse position.)

Table 7. Ratio of dermatology nurses to dermatologists, by province

Std.	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL
0.5	0.2	0.3	0.3	0.2	0.3	0.01	0.2	0.0	0.5	0.1

Source: Canadian Dermatology Nurses Association, 2010

This limited analysis suggests that Canada may not have capitalized on an opportunity to make more efficient use of dermatologists' time through the utilization of dermatology nurses. Billing codes which encourage dermatologists to hire certified dermatology nurses, with specialized training and skills to recognize and treat many skin conditions, will help to address long wait times.

> *"If trained nurses were available and there were the appropriate billing codes, wait times would definitely improve."*
>
> *— Dr. Benjamin Barankin, dermatologist, Toronto*

How have governments responded?

Some provincial and territorial governments have taken steps to improve access to dermatological care. Strategies include increasing the number of training places, negotiating dermatologist fees that encourage the practice of medical dermatology (instead of cosmetic dermatology), and/or improving outreach services.

However, these actions generally have fallen short of what is needed to achieve the level of access that Canadian skin patients expect and require.

Training new dermatologists

Training of new dermatologists is essential to replace retirees and to meet the growing demand for services. As stated earlier, governments and medical schools across Canada have done well in increasing in the number of dermatology places over the past 7 years.

In 2013, there were 29 graduates from dermatology residency programs (excluding visa students) — up from just 11 in 2011. These new entries will replace 5.6 per cent of full-time, medical dermatologists, a rate which approaches the target increase of 6.2 per cent annually, or 35 new practice entries.

Remuneration

A potential root cause of the shortage of medical dermatologists may be related to remuneration for medical services. Jurisdictions with comparatively low fees are at risk of diminishing numbers of dermatologists because those specialists may locate elsewhere and/or devote increased time to cosmetic services.

Although fees are not the only, or even the most important, reason for a dermatologist to practise in a certain area, an unrealistically low level of remuneration may limit the amount of time a dermatologist can afford to spend delivering insured services and may dissuade medical students from entering the profession.

In the following table *(Table 8. Comparison of dermatologist fees by province)*, fee payments for consultations and repeat visits were used as indicators of overall remuneration. Provinces and territories whose fees were at least 20 per cent less than the interprovincial average are shown in red and 20 per cent or more above are shown in white.

The comparison shows that British Columbia may be at risk of losing dermatologists whereas the Atlantic Provinces appear better positioned to recruit and retain dermatologists.

Table 8. Comparison of dermatologist fees by province

Visit Type	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL
Comp-rehen-sive consult	$60.68	$69.03	$84.15	$72.40	$72.92	$66.50	$117.71	$113.26	$123.24	$91.52
Repeat office visit	$22.55	$36.47	$36.79	$40.95	$27.11	$27.84	$44.70	$52.64	$33.06	$39.16
Overall rank	10	7	5	6	8	9	2	1	3	4

Legend: White: 20% or more above provincial average; Blue: within +/- 20%; Red: >20% below

Outreach to rural and remote communities

In no province is there a requirement for a certain minimum level of dermatology services to be available regardless of where citizens reside. For many of the 20 per cent of Canadians who live outside an urban area, outreach services are the only way they are able to access dermatological care.

Dermatologists spend, on average, only 7 per cent of their time providing outreach services -- much less than is needed. Considering that there are shortages of dermatologists in 6 of 10 provinces, the problem is compounded in these regions, creating a dire need.

> *"Access to dermatologists is trending in the wrong direction. Help is needed in less populated regions."*
>
> *— Dr. Marc Bourcier, Moncton, New Brunswick*

Teledermatology is one option to increase services in rural and remote areas. Assessments of the utility of teledermatology generally recommend that this technology be used to supplement rather than replace in-person care.[34,35]

Provincial governments and dermatologists have utilized this technology to varying degrees. All provinces have the available equipment and (except Quebec) include teledermatology consultations in their fee schedules. Yet, dermatologists interviewed for the Report Card said that it is infrequently used in practice. The Canadian Dermatology Association Workforce Survey reported that, in 2006, only 1 in 12 dermatologists used teledermatology, and only for an average of 3 hours a week. Overall, this amounted to only one-tenth of 1 per cent of all dermatologists' time, suggesting that there is potential to expand these services. However, this is unlikely to change until the number of dermatologists increases, since those with busy urban practices are unlikely to extend their referral area.

> *"Most dermatologists have such long wait lists in their office that they are not inclined to increase both their referral base and their workload. Increased dermatologist numbers would likely affect the uptake of teledermatology tremendously if a relative dermatologist surplus developed."*
>
> *— Dr. Evert Tuyp, dermatologist, Coquitlam, British Columbia*

Although dermatologists would like to make more use of the technology, liability issues are a concern where physical examination by a trained specialist plays a key role in diagnosis. Until these issues are resolved it is unlikely that teledermatology can achieve its potential to improve the quality of care and reduce costs of outreach services.

[34] Ndegwa, S., et al. Teledermatology Services: Rapid Review of Diagnostic, Clinical Management, and Economic Outcomes. Canadian Agency for Drugs and Technology in Health (CADTH). *Technology Report*. Issue 135, October 2010.

[35] Gagnon, Louise. Remote viewing: Teledermatology increases access to specialists in Canada. *Dermatology Times*. Aug 1, 2008.

CAPP recommendations to improve access to dermatological care

CAPP calls on federal, provincial and territorial governments to take the lead and to work in collaboration with dermatology professionals and patients to do the following:

1. **Reduce wait times** for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include:

- Developing a plan to achieve a minimum ratio of 1 full-time medical dermatologist per 62,500 population;
- Supporting certified dermatology nurses by creating billing codes for their services.

2. Require that basic dermatological care is provided **within reasonable commuting distance** for 90 per cent of residents by dermatologists and/or dermatology nurses. Options for achieving this goal may include:

- Ministries of Health to initiate a round table discussion to examine and find solutions for the limiting factors associated with the use of teledermatology services in rural and remote regions;
- Expanding outreach visits by dermatologists and/or dermatology nurses by addressing the underlying issues

3. Prepare to **meet future demands** for dermatological services, based on expected dermatologist retirements, population growth and rising incidences of skin diseases.

- Continue to expand the number of dermatology training places by 35 to achieve an overall annual increase in numbers of dermatologists of 6.2 per cent;
- Ensure that systems of remuneration support the recruitment and retention of medical dermatologists.

2. Lack of access to phototherapy

Phototherapy is recommended as an effective and inexpensive mode of treatment for psoriasis which complements topical and/or systemic drug therapy. Phototherapy, including psoralen/ultraviolet A (PUVA) and broad- and narrow-band UVB treatments, is a widely used, effective and non-invasive treatment for psoriasis and for many other skin conditions.

> *"Phototherapy is used for lots of conditions. It is a safe treatment that works really well, but there are huge accessibility issues."*
>
> *— Dr. B. Barankin, dermatologist, Ontario*

In some cases, it represents a cost-effective alternative which may also alleviate or slow the need for more expensive treatments or medications.

> *"Patients end up on biologics due to the restricted access to phototherapy."*
> *— Dr. Wayne Gulliver, dermatologist, St. John's*

How does Canada's performance rate?

Despite these clear benefits, Canada consistently fails to provide access to phototherapy services. These facilities are either non-existent, sparse or declining. Also, no provincial or territorial government includes home phototherapy as an insured service, which would allow psoriasis patients living beyond commuting distance from a phototherapy clinic to access this effective form of treatment.

Table 9. Performance ratings on access to medical procedures

CDN	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL	YT	NT	NU	NIHB
Fail	Fail	Fail	Fail	Fail	Fail	Fail	NI	Fail	Fail	Fail	Fail	NI	Fail	Fail

NI = needs improvement

Patients and dermatologists have increasingly reported the closure of phototherapy clinics. Hospital-based facilities, which are funded from global budgets, have closed in some areas due to cost pressures. In these centres, phototherapy is typically provided by physiotherapy

departments where treatments tend to be less expensive to provide. As a result of the closure of hospital units, phototherapy clinics based in dermatologists' offices cannot keep up with demand.

> *"There has been a positive increase in the number of dermatologists; however the therapies and testing capabilities have not kept up. There is only half of the phototherapy capacity needed."*
>
> *— Dr. Wayne Gulliver, dermatologist, St. John's*

Dermatologists report that the fees for providing phototherapy are insufficient to cover the costs of equipment, staff and facilities. For example, the cost of a set of UVB light bulbs is $3,000 and in a busy phototherapy practice these must be replaced every 6 to 12 months. The table below shows the fees paid for a narrow-band UVB phototherapy session in each province.

Table 10. Professional fees for narrow-band UVB phototherapy session

BC	AB	SK	MB	ON	QC	NB	NS	NL
$19.94	$20.42	$13.90	$27.24	$ 12.95	$17.40	$33.51	$33.06	$9.60

The chart below illustrates the correlation of fees paid to dermatologists to administer UVB treatments and the availability of phototherapy clinics. In most provinces, lower fees (shown in light green) are associated with fewer phototherapy clinics per population (shown in dark blue).

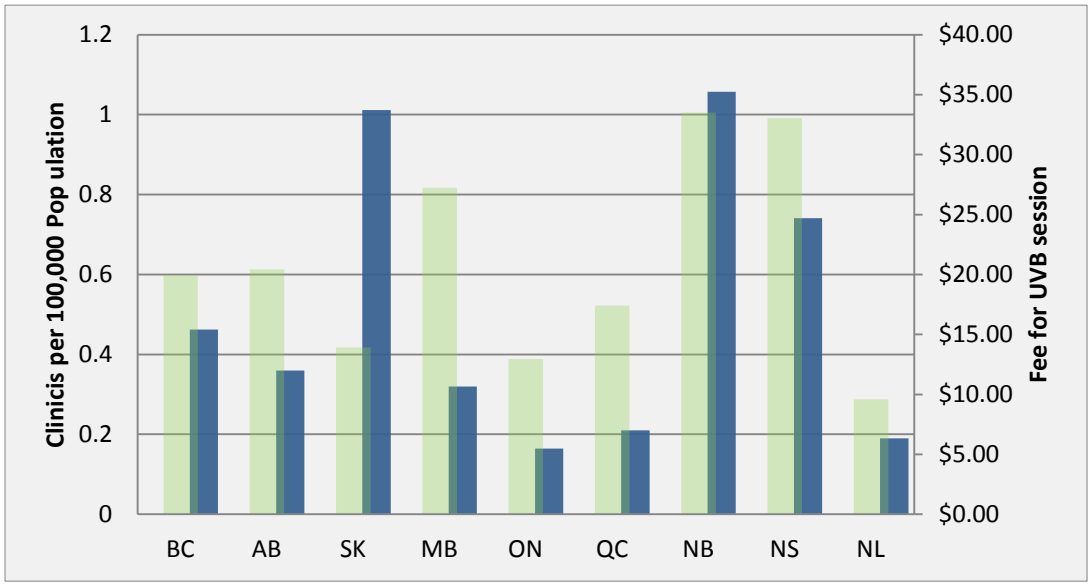


Figure 1. Relationship between dermatologist fees (green) and phototherapy clinics per 100,000 residents (blue)

It makes little sense that phototherapy, a relatively inexpensive therapeutic option for psoriasis and several other skin diseases, is not better supported. In situations where dermatologists cannot offer this procedure, often they must resort to prescribing treatments that have a much greater overall cost to the public purse.

> *"Reimbursement for phototherapy in Ontario is so low that it's impractical to provide it in the office—and hospitals are shutting down their facilities. It's even disappearing from the curriculum as therapy. Putting money into phototherapy would save money in the long term."*
>
> *— Dr. Charles Lynde, dermatologist, Toronto*

CAPP recommendation to improve access to medical procedures

The CAPP calls on the federal, provincial and territorial governments to take the lead, working in collaboration with dermatology professionals and patients, to ensure that every psoriasis patient in Canada has access to phototherapy by:

- Providing a phototherapy clinic in every publicly funded hospital;
- Including home phototherapy as an insured service for patients who cannot access a clinic.

3. Restricted access to standard drugs

In terms of access to drugs, although a few provinces have excellent records of providing standard therapy drugs, all jurisdictions place inordinate restrictions on their use.

The *Canadian Psoriasis Treatment Guidelines* recommend the use of several classes of medications — some topical and others systemic — as standard treatments.[36] Two main issues respecting access to standard drugs are:

- No province or territory covers all of the recommended medications
- Newer drugs are usually restricted
    - Patients must fail trials of 2 or more ineffective drugs, some having high toxicities
    - The restricted drug is provided in limited amounts and must be continually renewed
    - The paperwork involved in the special authorization process is complex for patients and onerous for dermatologists

CAPP believes that all drugs which are considered the standard of care in the treatment of skin diseases should be covered by government drug programs without restriction.

To assess performance in this area, we examined the formulary listings of medications which are considered the standard of care for psoriasis and psoriatic arthritis. The percentage of funded drugs was measured, as well as how many were restricted.

[36] *Canadian Guidelines for the Management of Plaque Psoriasis*, June 2009.

The following benchmarks were used to evaluate access to medications:

- Ninety per cent or more of a list of standard care drugs are covered. The CAPP's position is that 100 per cent of these drugs should be covered; this lower benchmark allows for the time needed by drug programs to review and list new medications;

- At least 80 per cent of drugs are available without restrictions. CAPP's position is that 100 per cent of drugs should be available without restriction; this lower level allows for restrictions due to patient safety.

How does Canada's performance rate?

Canada falls far short of the CAPP's benchmarks on access to medications.

Table 11. Performance ratings on access to medications

CDN	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL	YT	NT	NU	NIHB
Fail	Fail	NI	NI	NI	Fail	NI	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail

Legend: NI = needs improvement

Nationally, Canada fails to provide adequate access to medications, for several reasons.

1. Not all medications considered the standard of care to treat psoriasis and psoriatic arthritis are funded in every jurisdiction.

2. Where newer drugs are funded, most often there are arduous and time-consuming restrictions on their use which pose barriers to access and waste scarce dermatologist time.

Number of standard care drugs funded

Our analysis showed that four provinces met the CAPP benchmark standard of funding at least 90 per cent of standard care drugs for the treatment of psoriasis and psoriatic arthritis.

For those drugs that are not covered by the provincial formulary, unless patients have private insurance they must pay out of pocket. Psoriasis and psoriatic arthritis patients are often intolerant to side effects of drugs or need alternatives when medications lose effectiveness over time. For this reason, they need access to the widest possible range of choices.

Restricted access to standard drugs

Newer drugs may offer patients enhanced clinical benefit and improved quality of life[37] but are more likely to be restricted than older drugs. No jurisdiction came close to meeting the benchmark of 80 per cent of drugs being unrestricted— in fact, the highest score was 50 per cent.

While drug program managers may achieve some cost savings by delaying patients' access to newer therapies, Canadian studies have shown that costs are incurred elsewhere in the health system due to toxicities and lack of efficacy.[38] Particularly in psoriatic arthritis, the introduction of biologic therapies may have cost-neutral or cost-saving effects for patients who otherwise require long hospitalization periods.[39]

> *"It is not fair or appropriate to make a patient take cyclosporine before biologics. I don't think they understand that psoriasis is a chronic disease. What's the point in taking a short-term drug that is toxic to the kidneys in order to have a biologic approved?"*
>
> *— Dr. Benjamin Barankin, dermatologist, Toronto*

Restricted access criteria are arduous for patients and dermatologists alike. As shown in the table below, all jurisdictions require psoriasis and psoriatic arthritis patients to have tried and failed 2 or more treatments, often including methotrexate (a drug originally developed to treat cancer) and/or cyclosporine (a drug originally developed to prevent organ transplant rejection). Both of these drugs have toxicities that many patients are unable to withstand and have a limited duration of use. Since almost all moderate to severe psoriasis patients will likely eventually qualify for treatment with a biologic drug, it raises a question of why governments force skin patients to undergo these unpleasant and potentially dangerous ordeals before being allowed access to necessary treatments.

[37] Driessen, R. J. B., et al. The economic impact of high-need psoriasis in daily clinical practice before and after the introduction of biologics. *British Journal of Dermatology* 162.6 (2010): 1324-1329.

[38] Saurat, J-H., et al. High prevalence of potential drug-drug interactions for psoriasis patients prescribed methotrexate or cyclosporine for psoriasis: associated clinical and economic outcomes in real-world practice. *Dermatology* 220.2 (2010): 128-137.

[39] Driessen, R. J. B., et al. The economic impact of high-need psoriasis in daily clinical practice before and after the introduction of biologics. *British Journal of Dermatology* 162.6 (2010): 1324-1329.

> *"I don't see why we torture a patient for six months in order to get them the treatment they need."*
>
> *— Dr. Neil Shear, dermatologist, Toronto.*

Clearly, the administrative burden imposed on already overworked dermatologists to repeatedly complete and submit these applications on behalf of their patients is very time consuming. This process is a source of great frustration and, moreover, exacerbates the shortage of dermatologists.

> *"Simplify the process to get patients the treatment they need so that the doctors can spend less time doing complicated paperwork and be able to see more patients."*
> *— Dr. Irena Turchin, dermatologist, Fredericton*

Access to medications depends on where patients live

No province or territory funds all standard care drugs for the treatment of psoriasis and psoriatic arthritis. The following tables show the 'patchwork quilt' of drug access by jurisdiction. Access to standard care drugs depends on where patients live.

(tables continue on following page)

Table 12. Funding status by province of medications to treat psoriasis and psoriatic arthritis

Psoriasis drugs

Brand name (generic name)	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL	YT	NIHB
Methotrexate	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full
Dovonex (calcipotriol)	Full	Full	Full	SA	SA	Full	Full	Full	SA	Full	Full	Full
Dovobet (calcipotriol + betamethasone) ointment	Full	Full	Full	No	Full	SA	No	No	SA	No	Full	Full
Dovobet (calcipotriol + betamethasone) gel	Full	Full	Full	No	Full	SA	SA	SA	SA	SA	No	Full
Silkis (calcitriol cream)	No	No	No	No	SA	Full	No	No	No	No	No	No
Tazorac (tazarotene)	Full	Full	Full	SA	No	No	No	No	SA	SA	Full	Full
Neoral (cyclosporine)	SA	SA	SA	SA	SA	Full	SA	No	SA	SA	Full	No
Soriatane (acitretin)	Full	Full	SA	Full	Full	Full	Full	SA	Full	Full	SA	Full
Humira (adalimumab)	SA	SA	SA	SA	SA	SA	SA	No	SA	SA	SA	SA
Enbrel (etanercept)	SA	SA	SA	SA	SA	SA	SA	No	SA	SA	SA	No
Remicade (infliximab)	SA	SA	SA	SA	No	SA	SA	No	SA	SA	SA	No
Stelara (ustekinumab)	SA	SA	SA	SA	SA	SA	SA	No	SA	SA	No	SA

Abbreviations: *SA = Special Authorization (also called "limited use" and "exceptional drug status".)*

NIHB = Non-Insured Health Benefits. Covers registered First Nations and Inuit. NIHB formulary is used by NT and NU.

Table 13. Psoriatic arthritis drugs

Brand name (generic name)	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL	YT	NIHB
Methotrexate	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full	Full
Simponi (golimumab)	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	No	SA
Humira (adalimumab)	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA
Enbrel (etanercept)	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA
Remicade (infliximab)	SA	SA	SA	SA	SA	SA	No	No	No	No	SA	No

Abbreviations: SA = Special Authorization (also called "limited use" and "exceptional drug status".) NIHB = Non-Insured Health Benefits. Covers registered First Nations and Inuit. NIHB formulary is used by NT and NU.

Restrictions vary by province and territory

Each province and territory has a different hurdle that patients must reach in order to qualify to receive a biological medication. Depending on where an individual lives, he or she may or may not be eligible to receive newer treatments.

Table 14. Comparison of Special Authorization criteria for biologic medications for psoriasis[40]

Standard	BC	AB	SK	MB	ON
Baseline PASI score	PASI>12	PASI ≥10	not stated	PASI≥10	PASI≥10
BSA DLQI	BSA>10%	BSA>10%	not stated	BSA>10% or DLQI>10	BSA≥10% and DLQI≥10x

[40] Abbreviations used in Table 14:
MTX = Methotrexate; CS = Cyclosporine; Photo = phototherapy; DLQI =Dermatology Quality of LIfe Index; PASI = Psoriasis Area and Severity Index)

Standard	BC	AB	SK	MB	ON
Prior therapy	MTX + CS + photo	MTX or CS + photo	MTX + CS + photo	MTX, CS +/or photo	Several of: ≥3 topical agents Or photo Or 2 of: MTX, CS, acitretin

Table 14. Provinces continued below...

Standard	QC	NB	NS	NL	NIHB
Baseline PASI score	PASI ≥15	not stated	not stated	not stated	not stated
BSA DLQI	DQLI ≥15	BSA>10%	BSA>10%	BSA>10%	BSA>10%
Prior therapy	2 of: MTX, CS, acitretin + photo	MTX + CS + photo	MTX + CS + photo	MTX + CS + photo	MTX + CS + photo

Toxicities of older medications

As discussed earlier, most drug plans require a stepwise approach to therapy for psoriasis and psoriatic arthritis patients. Before trying a biological agent, patients with moderate to severe psoriasis typically are required to take methotrexate, cyclosporine and sometimes acitretin (Soriatane) as well as phototherapy. Psoriatic arthritis patients must try and fail on a non-steroidal anti-inflammatory drug (NSAID), corticosteroid and a disease-modifying drug such as cyclosporine, methotrexate or gold (although the latter is rarely used in practice). Exceptions are allowed if the patient cannot tolerate the medication or if there is a contraindication, or reason why the patient must not take the drug.

The following table contains basic information on contraindications and warnings associated with such drugs for the treatment of psoriasis and psoriatic arthritis. Patients having any of these conditions may be able to obtain biological drugs without first resorting to potentially toxic therapies.

Note that this table is for illustrative purposes only and does not substitute for consultation between patients and

their health professionals. Further discussion on this subject can be found in the *Canadian Psoriasis Treatment Guidelines* and detailed information is contained in the individual product monographs, available through Health Canada.

In addition to the information presented below, all drugs are contraindicated if the patient has hypersensitivity to any of the substances contained in the medication, including medicinal and non-medicinal ingredients.

Table 15. Contraindications and warnings for medications to treat psoriasis and psoriatic arthritis

Abbreviations: C=Contraindication W=Warning or precaution	Pregnancy and breast-	Liver or kidney disease	Gastro-intestinal	High blood pressure	High blood lipids	Alcohol	Immune disorders	Infection	Blood disorders	Cancer	Neurological and
Methotrexate	C	C				C	C	W	C		
Cyclosporine	W	C		C		W	C	C		C	
Soriatane	C	C			C	C*					W
NSAIDs	C	C	W						C		
Cortico-steroids			C	W				C			

* Alcohol must not be ingested during treatment and for 2 months following treatment.

There are also potential drug-drug interactions for all of the medications listed. Of particular relevance to psoriasis patients taking Soriatane (acitretin) is the contraindication for concomitant use of methotrexate. Further details on drug interactions can be found in the *Canadian Psoriasis Treatment Guidelines* and in the product monographs. Patients should always notify their prescriber of their medications before taking a new drug.

The widespread prevalence of contraindications and drug-drug interactions may put psoriasis patients at greater risk compared with patients with other diseases. A recent Canadian study found that psoriasis patients who were taking methotrexate and cyclosporine had greater risks of developing renal, gastrointestinal and pulmonary events

as well as significantly greater health care resource utilization and costs.[41] These costs, which are incurred elsewhere in the health system, negate savings that drug plan managers may achieve by requiring patients to take drugs with higher toxicities.

Drug review delays

Dermatologists interviewed for the Report Card object to the long delays by some provincial governments in reviewing and deciding on whether to fund new drugs. For example, British Columbia was the second-last province to approve biological drugs for the treatment of psoriasis, years after they were funded by private insurers and after they were available in other provincial drug programs. Prince Edward Island still does not fund this class of medications for psoriasis.

Patient support programs

Some psoriasis patients may be unable to access medications through their private or public insurance plans. Reasons may include:

- The medication is approved by Health Canada but is under review by the drug plan
- The medication has been reviewed by the drug plan and has been denied coverage
- The patient does not have private insurance (seasonal, part-time and self-employed workers are particularly affected) but does not qualify for a public drug program
- The deductible or co-payment is unaffordable

Pharmaceutical companies may offer support for the patient to receive their product through a Compassionate Use or Patient Assistance Program. These programs vary considerably between manufacturers. Some are informal, for example allowing a specialist to order a trade size of a product for a particular patient. Other programs are more extensive, such as offering access to a personal care specialist who works with both the patient and the physician to navigate the complex systems of access; coordinates training for injections; and completes paperwork for initiating and renewing Special

[41] Saurat, J-H., et al. High prevalence of potential drug-drug interactions for psoriasis patients prescribed methotrexate or cyclosporine for psoriasis: associated clinical and economic outcomes in real-world practice. *Dermatology* 220.2 (2010): 128-137.

Authorization drugs. In some cases, patients can enroll in a disease management program in which they receive educational materials and are followed up regularly.

Patients taking a brand name medication for psoriasis can check with the manufacturer to see if a patient program is available.

Patient Input into the Drug review process - Getting access to new drugs

Getting a psoriasis treatment approved for patient use follows several steps. Initially Health Canada checks to make sure that the medication is safe, and that the research results confirm that it does what the manufacturer claims it does. At this point it can be prescribed and purchased in Canada by those willing to pay out of pocket, or whose private insurance plans chose to cover the treatment right away.

The manufacturer usually (but not always) then makes a submission to the Common Drug Review via a division called CADTH in order to have their medicine available to Canadians via their provincial or territorial or government sponsored formulary. The CADTH review body looks at the manufacturer's clinical evidence, the prospective costs and also welcomes and considers submissions from registered patient organizations that bring the perspective of patients and their caregivers to the deliberation.

These patient submissions have become an important part of the review process and CADTH reports that well-prepared patient submissions can sometimes tip the balance in favour of a new medicine receiving a favourable recommendation. These groups can also later submit to the Ontario Drug Benefit Program and to the BC Pharmacare program. BC also welcomes submissions from individuals.

The Common Drug Review's recommendation then is delivered to a new body, called the Pan Canadian Pricing Alliance which can then elect a single province's Drug benefit team to enter into negotiations with the manufacturer, effectively setting a national cost for all the plans across the country that have opted in.

While the patient perspective is invited at the federal level and in BC and Ontario, other provincial/territorial plans will also consider letters from patients and patient organizations like CAPP and CSPA informally. It is crucial that decision makers learn from patients what it is like to live with psoriasis and/or psoriatic arthritis.

CAPP recommendation to improve access to medications

To all provincial, territorial and federal drug programs: Fund all drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.

Who is at risk?

While all one million Canadians with psoriasis and psoriatic arthritis are affected by these gaps in access to dermatological treatment and care, a few groups of patients are at particular risk. For example:

- Canadians living outside urban areas are increasingly vulnerable to shortages of dermatologists and to the expenses of travelling to receive necessary treatments;
- Atlantic Canadians and residents of Quebec, Saskatchewan and Manitoba have much longer wait times and less access to phototherapy. Residents of Yukon and Nunavut are entirely dependent on outreach services from neighbouring provinces;
- Psoriasis patients requiring phototherapy treatments are increasingly at risk because of phototherapy clinic closures and the need to travel long distances to receive treatments several times a week;

- Canadians without private insurance do not have the benefit of the prompt and broad access to medications that is generally provided by employer-sponsored drug plans.

What CAPP is doing

Psoriasis and psoriatic arthritis patients in Canada are represented by CAPP and by the Canadian Skin Patient Alliance in various capacities. These include

1. Providing information about the disease(s) through direct meeting with government decision-makers across the country to discuss the urgent issues of access to care and treatment
2. Making comprehensive submissions to CADTH, and the provinces using information gathered directly from patients
3. The publication and dissemination of this report card
4. Working with dermatologists to address the issues affecting the shortage of dermatologists in several jurisdictions
5. Working with the International Federation of Psoriasis Associations (IFPA) to have a Psoriasis resolution adopted by the World Health Organization (WHO)
6. Supporting individual patients and their families with online and personal support and information

Recommendations

Responsibility for addressing the issues outlined in this report lies with provincial and territorial governments; medical colleges, schools and professional associations; dermatologists; and patients. CAPP invites all stakeholders to be part of a concerted effort to improve access to dermatological care and treatment for all Canadians.

CAPP calls on provincial and territorial governments to take the lead regarding the following recommendations, in collaboration with dermatology professionals and patients.

Improve access to dermatological care

1. Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include:

    - Developing a plan to achieve a minimum ratio of 1 full-time medical dermatologist per 62,500 population;

- Supporting certified dermatology nurses by creating billing codes for their services.
- Supporting billing codes for physician-extenders

2. Require that basic dermatological care is provided within reasonable commuting distance for 90 per cent of residents by dermatologists and/or dermatology nurses. Options for achieving this goal may include:

- Ministries of Health to initiate a round table discussion to examine and find solutions for the limiting factors associated with the use of tele-dermatology services in rural and remote regions;
- Expanding outreach visits by dermatologists and/or dermatology nurses by addressing the underlying issues

3. Prepare to meet future demands for dermatological services, based on expected dermatologist retirements, population growth and rising incidences of skin diseases.

- Continue to expand the number of dermatology training places by 35 to achieve an overall annual increase in numbers of dermatologists of 6.2 per cent;
- Ensure that systems of remuneration support the recruitment and retention of medical dermatologists.

Improve access to phototherapy

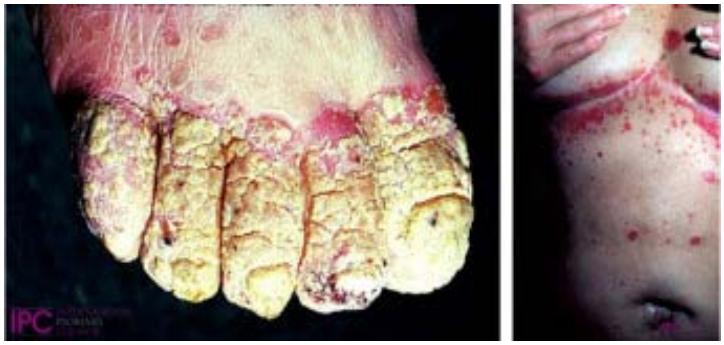
Ensure that every psoriasis patient in Canada has access to phototherapy by:

- Providing a phototherapy clinic in every publicly funded hospital;
- Including home phototherapy as an insured service for patients who cannot access a clinic.

Improve access to medications

Fund all drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.

Provincial and Territorial Report Cards



Access to:	Grade
Dermatological care	Fail
Phototherapy	Fail
Medications	Fail

British Columbia

Key issues

1. Patients experience long wait times for routine appointments with a dermatologist – on average 19 weeks, far in excess of the benchmark of 5 weeks.

The root cause of these delays may be related to the shortage of dermatologists in the province. There is only 1 full-time dermatologist for every 85,000 population in British Columbia, a much lower ratio than the 1:62,500 recommended by the Royal College of Physicians and Surgeons of Canada.

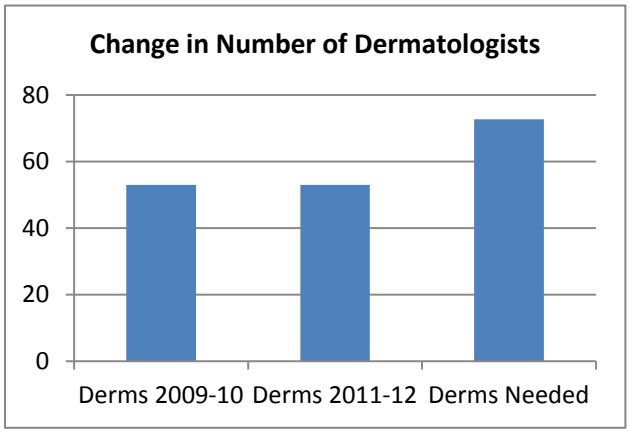
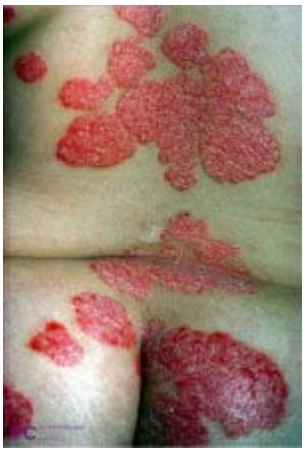


Figure 6. Change in Number of Dermatologists — BC

An analysis of billing data shows that while there are 70 dermatologists who practice in BC, not all of them practice full-time. This analysis shows that there are really just 51 full-time equivalent (FTE) medical dermatologists practising in British Columbia — a figure that has decreased slightly in the past 2 years. This number is far below the 73 FTE dermatologists needed in the province: an additional 22 new practice entries are needed. Another concern is that the average age of dermatologists in British Columbia is 57 – 3 years older than the average age of dermatologists across Canada and 4 years older than other clinical specialists in the

province. A high rate of expected retirements in the near future means that more new dermatologists will need to be trained as a matter of urgency. Some regions in BC have no dermatologists, forcing residents to travel long distances to access the care they need. This is a matter of some urgency. Local dermatologists and patients have been sounding the alarm, but so far little progress has been made.

One reason for the lack of increase in the number of full-time medical dermatologists may be the comparatively low rates of remuneration. As shown in the National section of this report card, British Columbia ranks last among all provinces in dermatology fees. As a result, new dermatologists tend to leave the province to practise elsewhere after completing their training in British Columbia. A few dermatologists have de-enlisted from the provincial program, either asking patients to pay out of pocket or leaving the province to practice in other provinces where the remuneration scales are higher. Currently BC is advertising for 24 new dermatologists, but after two years, they have been unable to attract new dermatologists.



2. Lack of access to phototherapy. While the British Columbia government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form of dermatological treatment—phototherapy—is rapidly disappearing. There is currently only 1 phototherapy clinic for every 216,000 British Columbians — much lower than the 1:62,500 ratio recommended by CAPP. The situation is especially acute for British Columbians living outside urban centres. Home phototherapy which is still not an insured service could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative

3. Restricted access to standard drugs. While British Columbia's public drug program lists many (88 per cent) standard drugs for the treatment of psoriasis and psoriatic arthritis, only 40 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** that pose barriers to access and waste scarce dermatologist time.

> *"At least three lower mainland hospitals have closed their phototherapy facilities due to budget cuts to physiotherapy departments."*
>
> *— Dr. Evert Tuyp, dermatologist, Coquitlam*

For psoriasis patients in British Columbia to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). British Columbia requires that a patient show an inability to tolerate or show a failure to respond to both of these systemic treatments in addition to phototherapy before granting coverage for one of the newer biologics. Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use.

Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments. As noted above, it is becoming increasingly difficult for patients to access phototherapy making this particular restriction to medications even more unreasonable.

Table 16. Performance of British Columbia on access to medications

Measure	British Columbia	Benchmark	Grade
Number of selected standard care drugs listed	94%	90%	Pass
Unrestricted drugs (of listed)	40%	80%	Fail

Table 17. Funding status of medications to treat psoriasis in British Columbia

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Full benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Full benefit	None required
Dovobet (calcipotriol + betamethasone) gel	Full benefit	None required
Silkis (calcitriol cream)	Not a benefit	

Medication	Listing Status	Special Authorization Criteria
Tazorac (tazarotene)	Full benefit	None required
Neoral (cyclosporine)	Special Authorization	Extensive psoriasis involving at least 25% of body surface or having psoriasis area and severity index of at least 12 PLUS treatment failure of the following: (a) topical therapy with corticosteroids; and (b) ultraviolet-B light or oral or topical methoxsalen plus ultraviolet-A light AND prescribed by a dermatologist or rheumatologist. OR Psoriasis of the palms and/or soles severe enough to interfere with daily living or work PLUS treatment failure on topical corticosteroids AND prescribed by a dermatologist.
Soriatane (acitretin)	Full benefit	None required
Humira (adalimumab) **Enbrel (etanercept)** **Remicade (infliximab)** **Stelara (ustekinumab)**	Special Authorization	Must be prescribed by a dermatologist *Initial coverage* All the following criteria have to be met: • Over 18 • Body Surface Area involvement >10% face, hands, feet, genital area • Failed to respond, intolerant to, unable to access UV phototherapy • Baseline pre-biologic PASI >12 • Failed to respond, intolerant to or has specific contraindication to methotrexate and cyclosporine (3 months trial) *Switching to another biologic* • Patient failed to achieve a PASI ≥ 75 from baseline naive PASI score after an initial trial of previous biologic • Patient failed to maintain a PASI ≥ 50 from baseline biologic naive PASI score while on maintenance therapy of previous biologic *Renewal of coverage* • First renewal after the initial 12 to 16 week trial of biologic: o Patient has obtained a PASI ≥ 75 from the baseline biologic naive PASI score • Subsequent renewals for maintenance therapy o Patient has maintained a PASI ≥ 50 from the baseline biologic naive PASI score

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab) **Humira (adalimumab)** **Enbrel (etanercept)** **Remicade (infliximab)**	Special Authorization	*Criteria for coverage for one year:* • Medication is prescribed by a rheumatologist or medical specialist in rheumatology • Diagnosis of moderate to severe psoriatic arthritis, where patient currently exhibits at least **two** of the following: o Five or more active joints o If oligoarticular (less than five joints), at least one active joint proximal to, or including, wrist or ankle o More than one joint with erosion on imaging study o Dactylitis of two or more digits o Tenosynovitis refractory to oral NSAIDs AND steroid injections o Enthesitis refractory to oral NSAIDs AND steroid injections (not required for Achilles tendon) o Inflammatory spinal symptoms refractory to two NSAIDs (minimum 4 week trial each) and submit a BASDAI with a score greater than 4 o Daily use of corticosteroids to control active arthritis o Use of narcotics >12 hours per day for pain resulting from inflammation • Functional assessment completed by patient o Health Assessment Questionnaire (HAQ) OR o BASDAI (in spinal disease) • Patient has failed two or more DMARDs: o Sulfasalazine (if allergic, must have failed **two** of the medications listed below) o Methorexate: up to 25 mg (15 mg for over 65 years) parenteral weekly o IM gold o Chlorquine and/or hydroxychloroquine o Azathioprine o Cyclosporine o Other (specify) *Criteria for renewal* • Medication is prescribed by a rheumatologist or medical specialist in rheumatology • For the criteria originally specified in the request for initial coverage, provide the current status • Functional assessment completed by patient

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of British Columbia to achieve the following goals, in collaboration with dermatology professionals and patients.

Improve access to dermatological care

a. Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include developing a plan to achieve a minimum ratio of 1 full-time medical dermatologist for every 62,500 people by adding at least 22 more dermatologists;

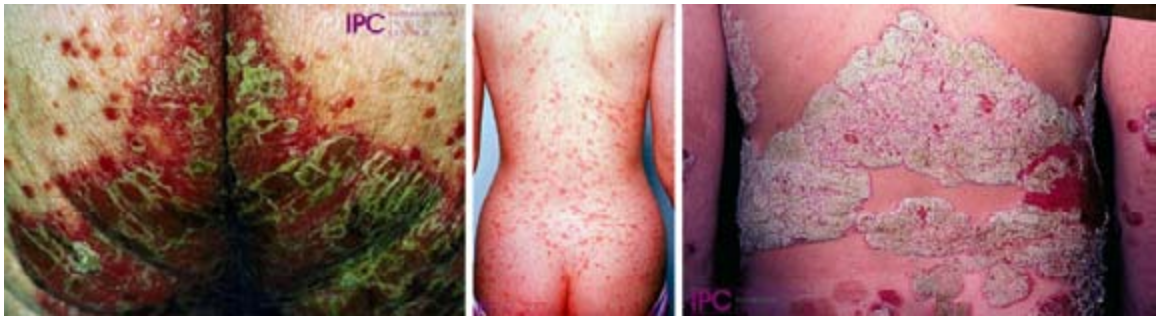
b. Increase the number of new practice entries by increasing the number of dermatology resident training places and by ensuring their retention with remuneration levels that are competitive with other provinces.

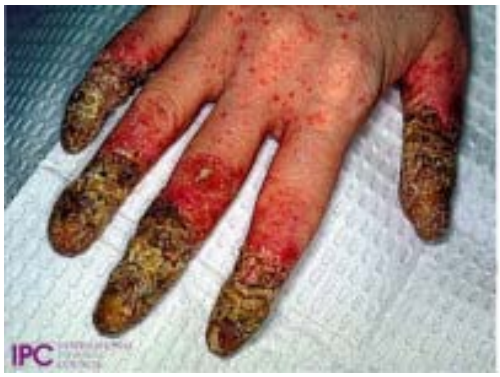
Improve access to phototherapy

Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians, together with their patients, make the decisions about which therapies are appropriate.





Access to:	Grade
Dermatological care	Pass
Phototherapy	Fail
Medications	Needs improvement

Alberta

Key issues

Patients in Alberta experience **long wait times** for routine appointments with a dermatologist – on average 8 weeks, considerably longer than the benchmark of 5 weeks. The root cause of these delays may be related to the shortage of dermatologists outside major centres. The province deserves credit for adding 3 dermatologists over the past 2 years. There is now 1 full-time dermatologist for every 60,000 population, which slightly exceeds the 1:62,500 ratio recommended by the Royal College of Physicians and Surgeons of Canada. However, most are located in the major urban areas.

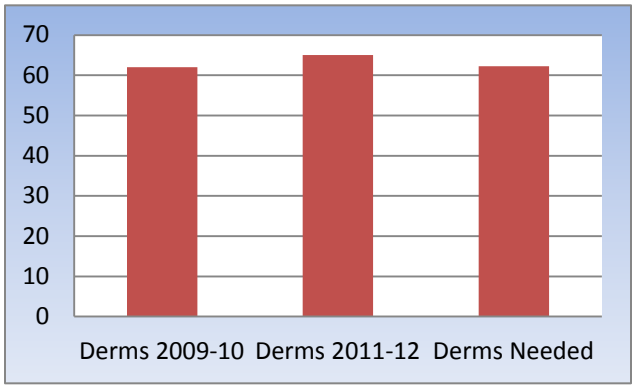
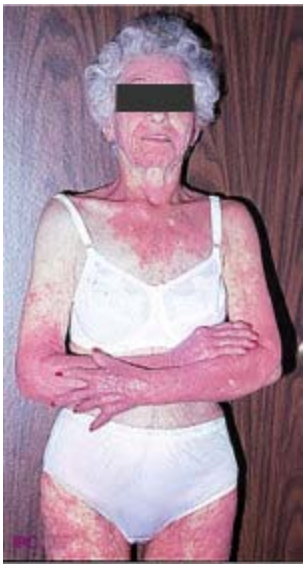


Figure 7. Change in Number of Dermatologists—AB

Lack of access to phototherapy. While the Alberta government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form of treatment for psoriasis —phototherapy—is rapidly disappearing. There is currently only 1 phototherapy clinic for every 277,000 Albertans — much lower than the 1:62,500 ratio recommended by CAPP. The situation is especially acute for Albertans living outside urban

centres because home phototherapy is not an insured service in the province. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.



Restricted access to standard drugs. While Alberta's public drug program lists almost all (94 per cent) standard drugs for the treatment of psoriasis and psoriatic arthritis, only 44 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** that pose barriers to access and waste scarce dermatologist time.

For psoriasis patients in Alberta to be prescribed newer biological treatments, they must first try and fail on phototherapy, and methotrexate or cyclosporine (itself a Limited Use medication). Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments. As noted above, it is difficult for patients to access phototherapy making this particular restriction to medications even more unreasonable.

Table 18. Performance of Alberta on access to medications

Measure	Alberta	Benchmark	Grade
Number of selected standard care drugs listed	94%	90%	Pass
Unrestricted drugs (of listed)	40%	80%	Fail

Table 19. Funding status of medications to treat psoriasis in Alberta

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Full benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Full benefit	None required
Dovobet (calcipotriol + betamethasone) gel	Full benefit	None required
Silkis (calcitriol cream)	Not a benefit	
Tazorac (tazarotene)	Full benefit	None required
Neoral (cyclosporine)	Special authorization	For the treatment of severe psoriasis in those patients where other standard therapy has failed. This drug product must be prescribed by a specialist in Dermatology. Special authorization for all criteria may be granted for 6 months. Eligible for auto-renewal.
Soriatane (acitretin)	Full benefit	None required
Humira (adalimumab)	Special authorization	Special authorization coverage may be provided for the reduction in signs and symptoms of severe, debilitating plaque psoriasis in patients who: - Have a total PASI of 10 or more and a DLQI of more than 11, OR - Who have significant involvement of the face, palms of the hands, soles of the feet or genital region; AND - Who are refractory or intolerant to:
Enbrel (etanercept)		

Medication	Listing Status	Special Authorization Criteria
Remicade (infliximab) **Stelara (ustekinumab)**		- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory, OR - Cyclosporine (6 weeks treatment); AND - Phototherapy (unless restricted by geographic location) Patients who have a contraindication to either cyclosporine or methotrexate will be required to complete an adequate trial of the other pre-requisite medication prior to potential coverage being considered. 'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above. 'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. For coverage, this drug must be prescribed by a Specialist in Dermatology ("Dermatology Specialist"). - Initial coverage may be approved as follows: [specific doses for each product] - Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period). - Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy. - Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed. For continued coverage [after the initial period] the patient must meet all of the following criteria: 1) The patient must be assessed by a Dermatology Specialist to determine response. 2) The Dermatology Specialist must confirm, in writing, that the patient is a 'responder' that meets the following criteria: - Greater than or equal to 75% reduction in PASI score, or - Greater than or equal to 50% reduction in PASI score AND improvement of greater than or equal to 5 points in the DLQI. Following this assessment, continued coverage may be considered for [specified dose] for a period of 12 months. Ongoing coverage may be considered if the patient is re-assessed by a Dermatology Specialist every 12 months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (2) above. PASI and DLQI scores are required for all requests for Plaque Psoriasis including those requests for patients that have significant involvement of the face, palms, soles of feet or genital region. All requests (including renewal requests) for infliximab for Plaque Psoriasis must be completed using the Adalimumab/ Etanercept/ Infliximab/ Ustekinumab for Plaque Psoriasis Special Authorization Request Form (ABC 31192).

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab) **Humira (adalimumab)** **Enbrel (etanercept)** **Remicade *(infliximab)***	Special authorization	Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory or intolerant to: - Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate -must have a trial of parenteral methotrexate before being accepted as refractory; AND - An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial). Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects. 'Refractory' is defined as lack of effect at the recommended doses and for duration of treatments specified above. 'Intolerant' is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. For coverage, this drug must be initiated by a Specialist in Rheumatology ("RA Specialist"). - Initial coverage may be approved for [a specified dosage and time interval]. - Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period). - Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy. - Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed. …/continued

Medication	Listing Status	Special Authorization Criteria
		1) The patient has been assessed by an RA Specialist to determine response; 2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by: - Confirmation of maintenance of ACR20, or - Maintenance of a minimum improvement of 1.2 units in DAS28 score (reported to one (1) decimal place) from baseline. 3) A current HAQ score (reported to two (2) decimal places) must be included with all renewal requests. It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above. All requests (including renewal requests) for golimumab for Psoriatic Arthritis must be completed using the Adalimumab/ Etanercept/ Golimumab/ Infliximab for Psoriatic Arthritis Special Authorization Request Form (ABC 30964).

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

"In Alberta, Special Access means 'no'."

— Dr. L. Parsons, dermatologist, Calgary

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Alberta to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

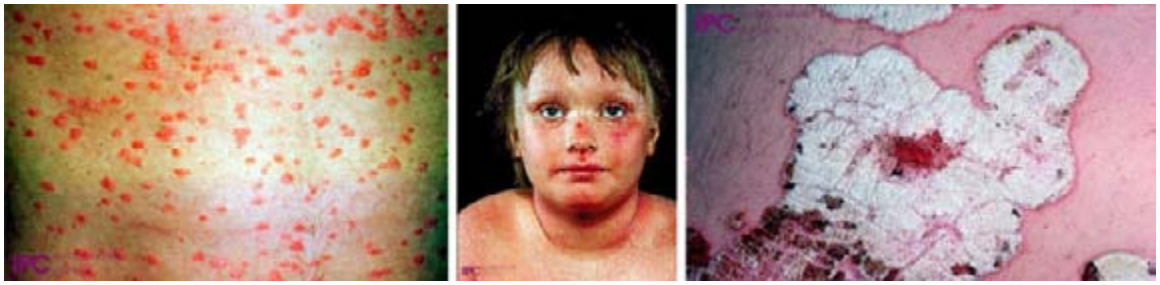
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include developing a plan to increase the number of outreach consultations to rural populations.

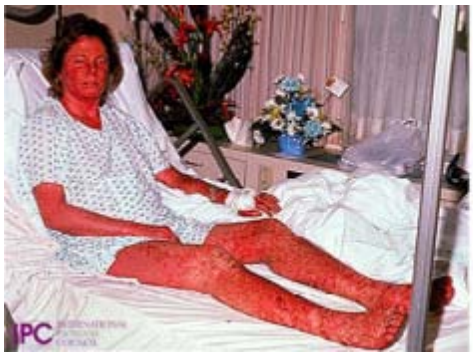
2. Improve access to phototherapy

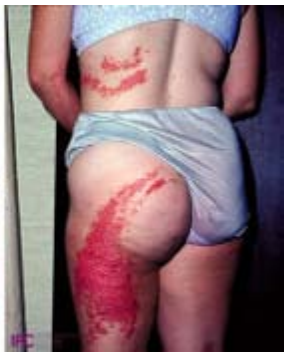
Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







Access to:	Grade
Dermatological care	Fail
Phototherapy	Fail
Medications	Needs improvement

Saskatchewan

Key issues

1. Patients in Saskatchewan experience **long wait times** for routine appointments with a dermatologist – on average 14 weeks, much longer than the benchmark of 5 weeks. The root cause of these delays may be related to the shortage of dermatologists in the province. Despite adding 1 dermatologist since 2010, there is still only 1 full-time dermatologist for every 217,500 population in the province, a much lower ratio than the 1:62,500 recommended by the Royal College of Physicians and Surgeons of Canada. Saskatchewan has taken steps to alleviate the shortage by contracting with medical schools in other provinces to train dermatology residents having a Return of Service contract. For example, a dermatology resident is expected to graduate from Dalhousie University in 2014. The need for more trainees is even more acute considering the average age of dermatologists in Saskatchewan is now 59 – 4 years older than the average in Canada and 9 years older than all clinical specialists in the province.

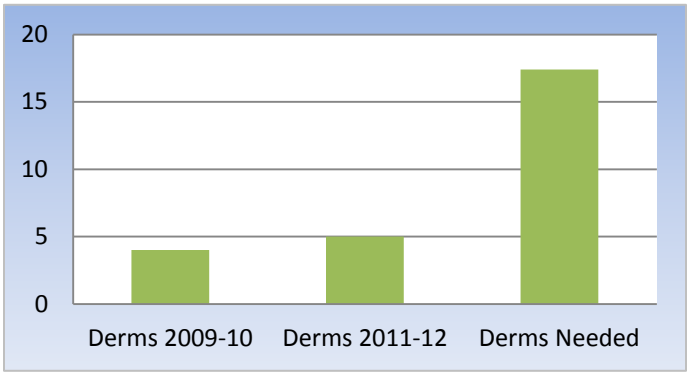
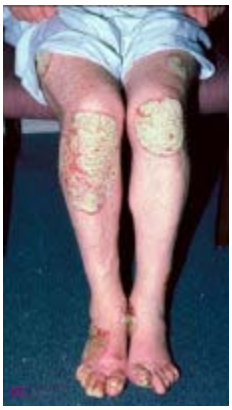


Figure 8. Change in Number of Dermatologists—SK

2. **Lack of access to phototherapy.** While the Saskatchewan government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form of treatment for psoriasis —phototherapy—is inadequate. There is currently only 1 phototherapy clinic for every 98,900 residents — much lower than the 1:62,500 ratio recommended by CAPP. The situation is especially acute for those living outside urban centres since home phototherapy is not an insured service in the province. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.

3. While Saskatchewan's public drug program lists almost all (94 per cent) standard drugs for the treatment of psoriasis and psoriatic arthritis, only 38 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** that pose barriers to access and waste scarce dermatologist time.



   For psoriasis patients in Saskatchewan to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). Saskatchewan requires that a patient show an intolerance to or lack of response to both of these systemic treatments in addition to phototherapy before granting coverage for one of the newer biologics. Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use.

4. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments. As noted above, it is difficult for patients to access phototherapy making this particular restriction to medications even more unreasonable.

Table 20. Performance of Saskatchewan on access to medications

Measure	Saskatchewan	Benchmark	Grade
Number of selected standard care drugs listed	88%	90%	Needs improvement
Unrestricted drugs (of listed)	29%	80%	Fail

Table 21. Funding status of medications to treat psoriasis in Saskatchewan

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Full benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Full benefit	None required
Dovobet (calcipotriol + betamethasone) gel	Full benefit	None required
Silkis (calcitriol cream)	Not a benefit	
Tazorac (tazarotene)	Full benefit	None required
Neoral (cyclosporine)	Exceptional Drug Status	For induction and maintenance of remission of severe psoriasis in patients for whom conventional therapy is ineffective or inappropriate.
Soriatane (acitretin)	Exceptional Drug Status	For treatment of severe intractable psoriasis
Humira (adalimumab) Enbrel (etanercept) Remicade (infliximab) Stelara (ustekinumab)	Exceptional Drug Status	For treatment of adult patients with severe debilitating plaque psoriasis who meet all of the following criteria: i) failure to respond to, contraindications to, or intolerant to methotrexate and cyclosporine; AND ii) failure to respond to, intolerant to or unable to access phototherapy. Coverage will be approved initially for the induction phase of up to 16 weeks. Coverage can be renewed in patients who have responded to therapy. This product should be used in consultation with a specialist in this area.

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab)	Exceptional Drug Status	For treatment of psoriatic arthritis in patients who have failed or are intolerant to methotrexate and one other DMARD. Note: Exceptions can be considered in cases where methotrexate or leflunomide are contraindicated. Treatment should be combined with an immunosuppressant.
Humira (adalimumab)		
Enbrel (etanercept)		
Remicade (infliximab)		

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Saskatchewan to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care:

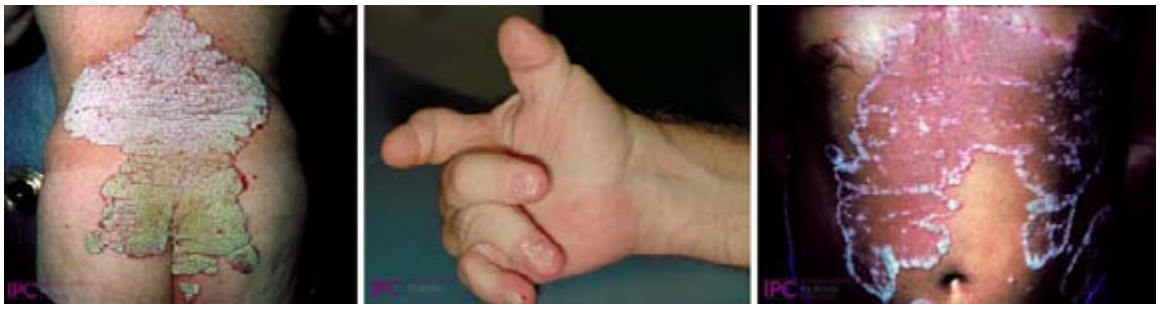
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include developing a plan to achieve a minimum ratio of 1 full-time medical dermatologist for every 62,500 people by training at least 12 dermatologists. Saskatchewan should expand its successful Return of Service contracts with dermatology residents trained outside the province;

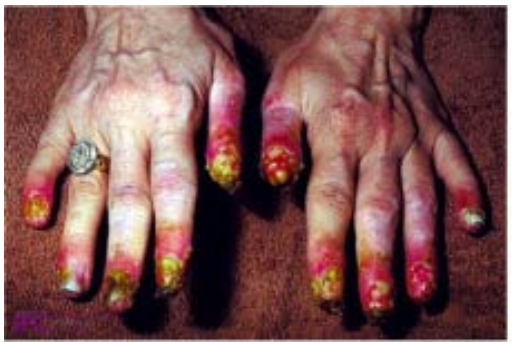
2. Improve access to phototherapy:

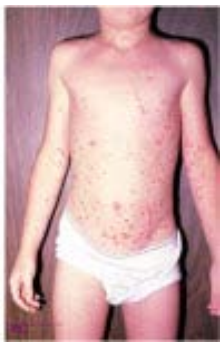
Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications:

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







Access to:	Grade
Dermatological care	Needs improvement
Phototherapy	Fail
Medications	Needs improvement

Manitoba

Key issues

1. Patients in Manitoba and Saskatchewan experience **long wait times** for routine appointments with a dermatologist – on average 14 weeks, much longer than the benchmark of 5 weeks. The root cause of these delays may be related to the location of dermatologists in the province. Three dermatologists have been added in Manitoba over the past 2 years, achieving a ratio of 1 full-time dermatologist for every 69,444 population in the province, somewhat above the 1:62,500 ratio recommended by the Royal College of Physicians and Surgeons of Canada. Manitoba deserves praise for training new dermatologists through its Return of Service arrangements with residents trained in other provinces. The additional graduate from the University of British Columbia in 2014 will bring Manitoba's ratio of dermatologists to population closer to the recommended standard. However, dermatologists are located in urban centres, so rural populations may not have access to their services.

2. **Lack of access to phototherapy.** A primary form of treatment for psoriasis —phototherapy—is scarce in Manitoba. There are currently only 8 phototherapy clinics in the province of 1.25 million people — a ratio of 1 clinic for every 156,250 residents: far lower than the 1:62,500 ratio recommended by CAPP. The situation is especially acute for those living outside major centres. Home

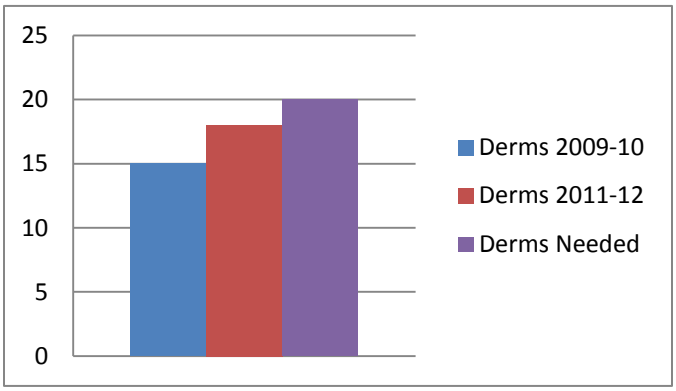


Figure 9. Changes in Number of Dermatologists—MB

phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.

3. **Restricted access to medications**. While Manitoba's public drug program lists almost all (94 per cent) standard drugs for the treatment of psoriasis and psoriatic arthritis, less than 1 in 3 (31 per cent) listed drugs is available to all patients without the **unreasonable and time-consuming restrictions** that pose barriers to access and waste scarce dermatologist time.

Table 22. Performance of Manitoba on access to medications

Measure	Manitoba	Benchmark	Grade
Number of selected standard care drugs listed	88%	90%	Needs improvement
Unrestricted drugs (of listed)	21%	80%	Fail

Table 23. Funding status of medications to treat psoriasis in Manitoba

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Benefit with criteria	When prescribed where standard therapy has failed
Dovobet (calcipotriol + betamethasone) ointment	No	Individual separate ingredients are benefits
Dovobet (calcipotriol + betamethasone) gel	No	Individual separate ingredients are benefits
Silkis (calcitriol cream)	Not a benefit	
Medication		

Medication	Listing Status	Special Authorization Criteria
Tazorac (tazarotene)	Benefit with prior approval	When prescribed where standard therapy has failed.
Neoral (cyclosporine)	Benefit with prior approval	Psoriasis resistant to topical treatments (steroids, coal tar), systemic retinoids, methotrexate, hydroxyurea, PUVA, UVB treatment
Soriatane (acitretin)	Benefit	Not applicable
Humira (adalimumab) **Enbrel (etanercept)** **Remicade (infliximab)** **Stelara (ustekinumab)**	Benefit with prior approval	For treatment of adult patients with severe plaque psoriasis presently with one or more of the following: • Psoriasis Area and the Severity Index (PASI) ≥ 10 • Body Surface Area (BSA) > 10% • Significant involvement of the face, hands feet or genital region • Dermatology Life Quality Index (DLQI) > 10 AND • Failure to respond to, contraindications to, intolerant to or unable to access methotrexate, cyclosporine and/or phototherapy. Coverage will be approved initially for a maximum of 3 or 4 months [depending on the biologic]. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits: • ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI • ≥ 75 % reduction in the PASI score • ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region. *Request for coverage must be made by a specialist in dermatology.*

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab)	Benefit with prior approval	For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value. *Request for coverage must be made by a specialist in rheumatology.*
Humira (adalimumab)		
Enbrel (etanercept)		
Remicade (infliximab)		

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

4. non-steroidal anti-inflammatory drugs
5. corticosteroids
6. methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Manitoba to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

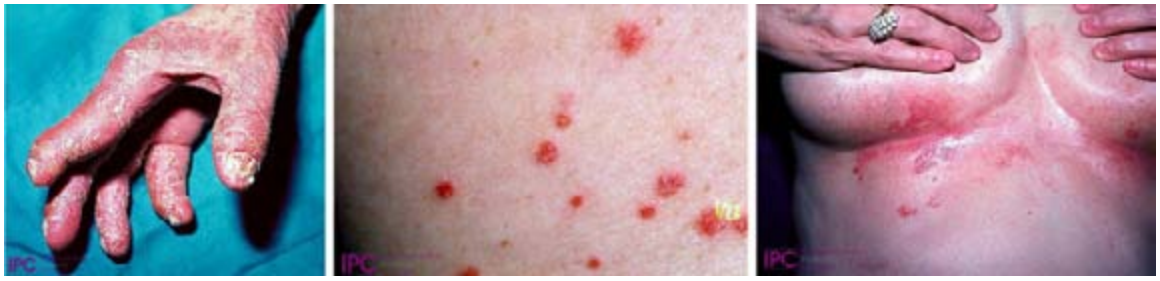
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include increasing training places and continuing the successful Return of Service contracts for dermatology residents trained outside the province. Also, the Saskatchewan could develop a plan to increase outreach to rural populations;

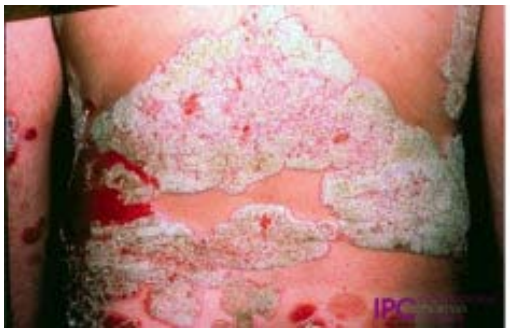
2. Improve access to phototherapy

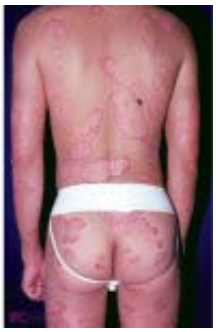
Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







Access to:	Grade
Dermatological care	Needs improvement
Phototherapy	Fail
Medications	Fail

Ontario

Key issues

1. Patients in Ontario experience **long wait times** for routine appointments with a dermatologist – on average 12 weeks, much longer than the benchmark of 5 weeks. The root cause of these delays may be related to the shortage of dermatologists in the province. Despite adding 11 dermatologists over the past 2 years, there is still only 1 full-time dermatologist for every 72,100 population in the province, a lower ratio than the 1:62,500 recommended by the Royal College of Physicians and Surgeons of Canada. Also, most are located in major urban centres. As shown in the National section of this report card, Ontario has the third-lowest rates of remuneration in the country, which may act as a disincentive for new dermatologists to remain in the province after receiving their training.

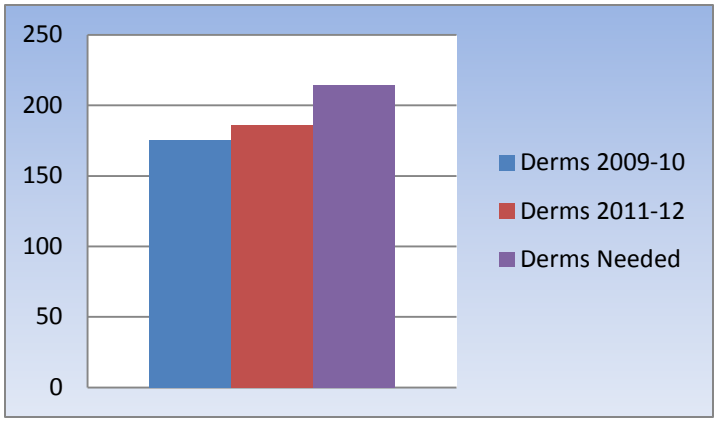
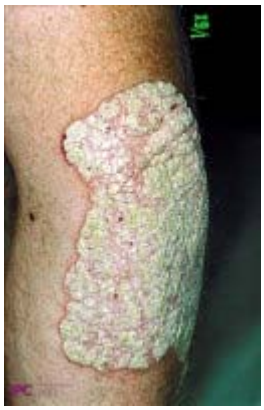


Figure 10. Change in Number of Dermatologists—ON

2. **Lack of access to phototherapy.** While the Ontario government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form

of treatment for psoriasis —phototherapy—is difficult to access. There is only 1 phototherapy clinic for every 610,000 residents — the highest ratio in the country and an order of magnitude greater than the 1:62,500 ratio recommended by CAPP. For patients living outside urban centres, the situation is far worse since home phototherapy is not an insured service in the province. This situation is likely linked to the very low rates of remuneration for phototherapy services; although Ontario has increased fees from $7.85 to $12.95 over the past 2 years, the province lags well behind all but one of its peers in this regard. (See the National section of this report card for details.) Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.



3. **Lack of access to medications.** While Ontario's public drug program lists many (88 per cent) standard drugs for the treatment of psoriasis and psoriatic arthritis, only 1 in 3 (33 per cent) listed drugs is available to all patients without the **unreasonable and time-consuming restrictions** that pose barriers to access and waste scarce resources.

Table 24. Performance of Ontario on access to medications

Measure	Ontario	Benchmark	Grade
Number of selected standard care drugs listed	81%	90%	Needs improvement
Unrestricted drugs (of listed)	31%	80%	Fail

Table 25. Funding status of medications to treat psoriasis in Ontario

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Limited Use	For the treatment of psoriasis in patients who have failed topical corticosteroids alone, or are intolerant to topical corticosteroids
Dovobet (calcipotriol + betamethasone) ointment	Open benefit	Therapeutic note: For use in patients with psoriasis who have failed 1st line topical steroids and Dovonex (calcipotriol) therapy.
Dovobet (calcipotriol + betamethasone) gel	Open benefit	Therapeutic note: For the treatment of moderate to severe scalp psoriasis in patients who have failed first-line topical corticosteroid therapy
Silkis (calcitriol cream)	Limited Use	For the treatment of psoriasis in patients who have failed topical corticosteroids alone, or are intolerant to topical corticosteroids
Tazorac (tazarotene)	Not a benefit	
Neoral (cyclosporine)	Limited Use	For the treatment of psoriasis in patients who have failed, or are intolerant to, other systemic therapies, including methotrexate, acitretin or PUVA
Soriatane (acitretin)	Open benefit	Therapeutic note: This drug should be used with extreme caution in females of childbearing potential due to its teratogenicity. Effective contraception must be practised for at least 2 years following discontinuation
Remicade (infliximab)	Not a benefit	Not a benefit for psoriasis

Medication	Listing Status	Special Authorization Criteria
Humira (adalimumab)	Limited Use	For the treatment of psoriasis in patients who have failed, or are intolerant to other systemic therapies, including methotrexate,cyclosporine or soriatane. A: For the treatment of severe* plaque psoriasis in patients 18 years of age or older who have experienced failure, intolerance, or have a contraindication to adequate trials of several standard therapies**. Claims for the first 6 months must be written by a dermatologist. Monitoring of patients is required to determine if continuation of therapy beyond 12 weeks is required. Patients not responding adequately at 12 weeks should have treatment discontinued. * Definition of severe plaque psoriasis: Body Surface Area (BSA) involvement of at least 10%, or involvement of the face, hands, feet or genital regions, AND Psoriasis Area and Severity Index (PASI) score of at least 10 (not required if there is involvement of the face, hands, feet or genital regions), AND Dermatology Life Quality Index (DLQI) score of at least 10. ** Definition of failure, intolerance or contraindication to adequate trials of standard therapies: 6 month trial of at least 3 topical agents including vitamin D analogues and steroids 12 week trial of phototherapy (unless not accessible) 6 month trial of at least 2 systemic, oral agents used alone or in combination Methotrexate 15-30mg per week Acitretin (could have been used with phototherapy) Cyclosporine Maintenance/Renewal: After 3 months of therapy, patients who respond to therapy should have: At least a 50% reduction in PASI, AND at least a 50% reduction in BSA involvement, AND at least a 5 point reduction in DLQI score Approvals will only allow for standard dosing. If the patient has not responded adequately after 12 weeks of treatment at the Health Canada approved dose, higher doses are not recommended and the physician should consider switching to an alternative biologic agent.
Enbrel (etanercept)		
Stelara (ustekinumab)	Limited Use	

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab) Humira (adalimumab) Enbrel (etanercept)	Exceptional Access	For the treatment of psoriatic arthritis in patients who have: Severe active disease (≥5 swollen joints and radiographic evidence of psoriatic arthritis) despite treatment with methotrexate (20mg/week) for at least 3 months and one of leflunomide (20mg/day) or sulfasalazine (1g twice daily) for at least 3 months. If the patient has documented contraindications or intolerances to methotrexate, then only one of leflunomide (20 mg/day) or sulfasalazine (1 g twice daily) for at least 3 months is required. Details of contraindications and intolerances must also be provided. Renewal will be considered for patients with objective evidence of at least 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 preservation of treatment effect must be provided. The planned dosing regimen for the requested biologic should be provided. The recommended doses for the treatment of psoriatic arthritis are as follows: o Adalimumab 40mg every two weeks o Etanercept 25mg twice weekly or 50mg once weekly o Golimumab 50mg once a month
Remicade (infliximab)	Not a benefit	Not a benefit for psoriatic arthritis

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Ontario to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

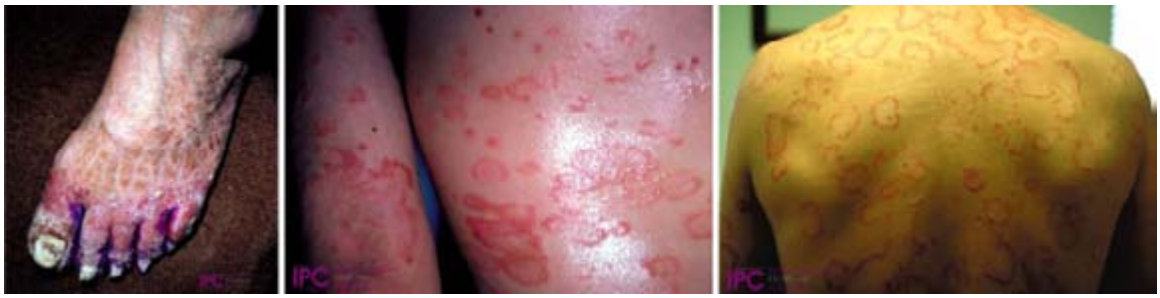
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include developing a plan to achieve a minimum ratio of 1 full-time medical dermatologist for every 62,500 people by training an additional 29 dermatologists, and by expanding outreach services;

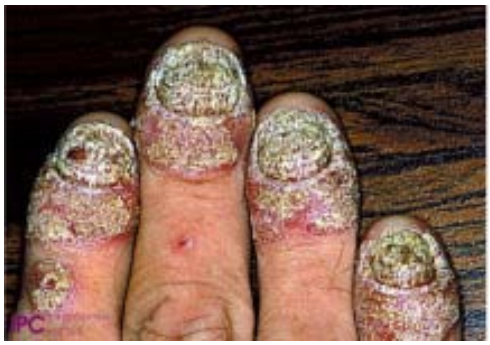
2. Improve access to phototherapy

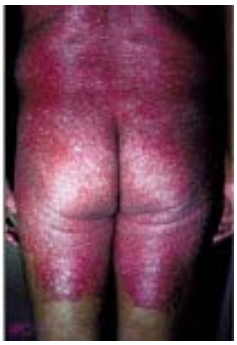
Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







Access to:	Grade
Dermatological care	Pass
Phototherapy	Fail
Medications	Needs improvement

Quebec

Key issues

1. Patients in Quebec experience **long wait times** for routine appointments with a dermatologist – on average 18 weeks, very much longer than the benchmark of 5 weeks. Four more dermatologists are practising full-time in Quebec compared with 2 years ago and there is now one full-time dermatologist for every 53,500 population in the province, a higher ratio than the 1:62,500 recommended by the Royal College of Physicians and Surgeons of Canada. In light of the abundance of dermatologists in the province, the high wait times are perplexing. A root cause may be related to remuneration. As shown in the National section of this report card, dermatology fees in Quebec are the second-lowest in the country, which may be a disincentive for dermatologists to provide medical services.

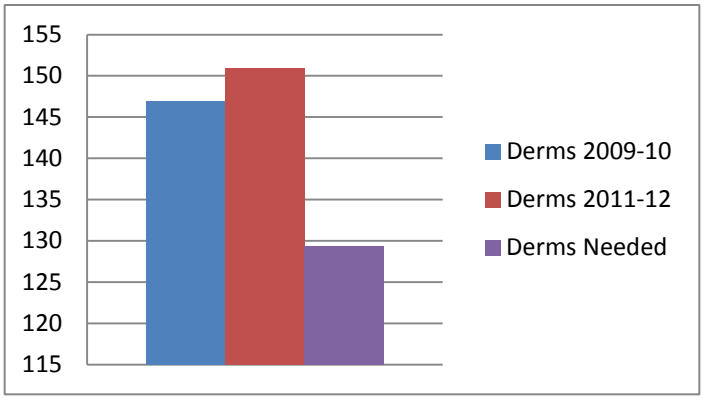
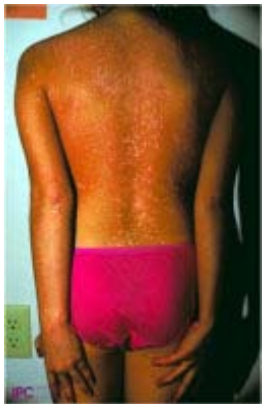


Figure 11. Changes in Number of Dermatologists—QC

2. **Lack of access to phototherapy.** While the Quebec government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form of treatment for psoriasis —phototherapy—is difficult to access. There is currently only

1 phototherapy clinic for every 479,000 residents, far exceeding the 1:62,500 ratio recommended by CAPP. The situation is especially acute for those living outside major centres since home phototherapy is not an insured service in the province. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.



3. **Restricted access to medications.** While the Quebec government lists almost all (94 per cent) standard drugs for the treatment of psoriasis and psoriatic arthritis on its public drug formulary, only 38 per cent of these drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time. In particular, Quebec has the **most restrictive Special Authorization criteria** of all provinces for biological drugs. Psoriasis patients must have a Psoriasis Area and Severity Index (PASI) score of 15 or greater (as well as have failed on at least 2 older medications plus phototherapy) before their application is considered. All other provinces require a PASI score of 10 or greater. (See the National section of this report card for details.)

Table 26. Performance of Quebec on access to medications

Measure	Quebec	Benchmark	Grade
Number of selected standard care drugs listed	94%	90%	Pass
Unrestricted drugs (of listed)	47%	80%	Fail

Table 27. Funding status of medications to treat psoriasis in Quebec

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Full benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Full benefit	None required
Dovobet (calcipotriol	Full benefit	None required

Medication	Listing Status	Special Authorization Criteria
+ betamethasone) gel		
Silkis (calcitriol cream)	Full benefit	None required
Tazorac (tazarotene)	Not a benefit	
Neoral (cyclosporine)	Full benefit	None required
Soriatane (acitretin)	Full benefit	None required
Humira (adalimumab)	Exceptional medication	For treatment of persons suffering from a severe form of chronic plaque psoriasis: • in the presence of a score greater than or equal to 15 on the Psoriasis Area and Severity Index (PASI) or of large plaques on the face, palms or soles or in the genital area; and • in the presence of a score greater than or equal to 15 on the Dermatology Quality of Life Index (DQLI) questionnaire; and• where a phototherapy treatment of 30 sessions or more for three months has not made it possible to optimally control the disease, unless the treatment is contraindicated, not tolerated or not accessible or unless a treatment of 12 sessions or more for one month has not provided significant improvement in the lesions;
Enbrel (etanercept)		
Remicade (infliximab)		
Stelara (ustekinumab)		

Medication	Listing Status	Special Authorization Criteria
		or - acitretin at a dose of 25 mg or more per day. The initial request is authorized for a maximum four months. When requesting continuation of treatment, the physician must provide information making it possible to establish the treatment's beneficial effects, specifically: • an improvement of at least 75% in the PASI score; or • an improvement of at least 50% in the PASI score and a decrease of at least five points on the DQLI questionnaire; or • a significant improvement in lesions on the face, palms or soles or in the genital area and a decrease of at least five points on the DQLI questionnaire. Requests for continuation of treatment are authorized for a maximum of six months. Authorizations for [the biological drug] are given for [a specified] induction dose, followed by a maintenance treatment [at a specified schedule and dose].

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab) **Humira (adalimumab)** **Enbrel (etanercept)** **Remicade (infliximab)**	Exceptional medication	For treatment of moderate or severe rheumatoid arthritis or of moderate or severe psoriatic arthritis: of the rheumatoid type; Upon initiation of treatment or if the person has been receiving the drug for less than five months: • the person must, prior to the beginning of treatment, have eight or more joints with active synovitis and one of the following five elements must be present: - a positive rheumatoid factor for rheumatoid arthritis only; - radiologically measured erosions; - a score of more than 1 on the Health Assessment Questionnaire (HAQ); - an elevated C-reactive protein level; - an elevated sedimentation rate, and • the disease must still be active despite treatment with two disease-modifying anti-rheumatic drugs, used either concomitantly or not, for at least three months each. Unless there is serious intolerance or a serious contraindication, one of the two drugs must be: for rheumatoid arthritis: - methotrexate at a dose of 20 mg or more per week; for psoriatic arthritis of the rheumatoid type: - methotrexate at a dose of 20 mg or more per week, or - sulfasalazine at a dose of 2 000 mg per day. The initial request is authorized for a maximum of five months. When requesting continuation of treatment, the physician must provide information making it possible to establish the treatment's beneficial effects, specifically: • a decrease of at least 20% in the number of joints with active synovitis and one of the following four elements: - a decrease of 20% or more in the C-reactive protein level; - a decrease of 20% or more in the sedimentation rate; - a decrease of 0.20 in the HAQ score; - a return to work.

Medication	Listing Status	Special Authorization Criteria
	Exceptional medication	Requests for continuation of treatment are authorized for a maximum period of 12 months. For rheumatoid arthritis, authorizations for [the biologic drug] are given for a [specified dosage schedule]. However, after [a specified number of] weeks of treatment with [the biologic drug] as monotherapy, an authorization may be given for [a specified dosage schedule]. For psoriatic arthritis of the rheumatoid type, authorizations for [the biologic drug] are given for a [specified dosage schedule]; For treatment of moderate or severe psoriatic arthritis of a type other than rheumatoid; Upon initiation of treatment or if the person has been receiving the drug for less than five months: • the person must, prior to the beginning of treatment, have at least three joints with active synovitis and a score of more than 1 on the Health Assessment Questionnaire (HAQ), And • the disease must still be active despite treatment with two disease-modifying anti-rheumatic drugs, used either concomitantly or not, for at least three months each. Unless there is serious intolerance or a serious contraindication, one of the two drugs must be: - methotrexate at a dose of 20 mg or more per week, or - sulfasalazine at a dose of 2 000 mg per day. The initial request is authorized for a maximum of five months. When requesting continuation of treatment, the physician must provide information making it possible to establish the treatment's beneficial effects, specifically: • a decrease of at least 20% in the number of joints with active synovitis and one of the following four elements: - a decrease of 20% or more in the C-reactive protein level; - a decrease of 20% or more in the sedimentation rate; - a decrease of 0.20 in the HAQ score; - a return to work. Requests for continuation of treatment are authorized for a maximum period of 12 months. Authorizations for [the biologic drug] are given for a [specified dosage schedule].

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Quebec to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

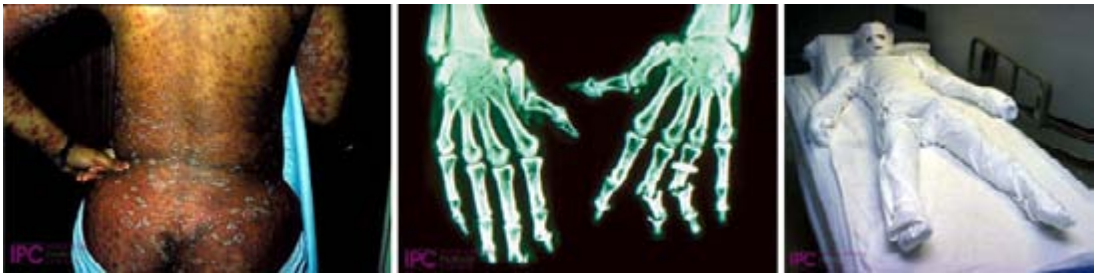
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include examining root causes and rates of remuneration;

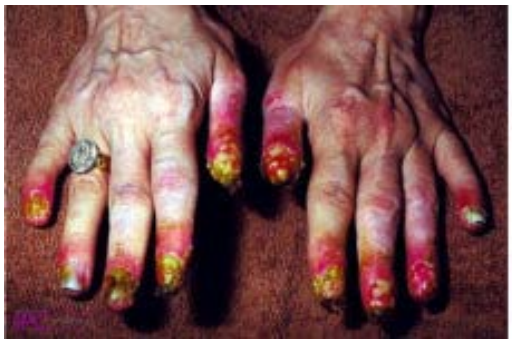
2. Improve access to phototherapy

Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.





Access to:	Grade
Dermatological care	Fail
Phototherapy	Needs Improvement
Medications	Fail

New Brunswick

Key issues

1. Patients in Atlantic Canada experience **long wait times** for routine appointments with a dermatologist – on average 23 weeks, the longest in Canada and very much longer than the benchmark of 5 weeks. The root cause of these delays may be related to the shortage of dermatologists. In 2014, there is only 1 full-time dermatologist for every 75,700 population in New Brunswick, a much lower ratio than the 1:62,500 recommended by the Royal College of Physicians and Surgeons of Canada. The province has not seen an increase in the number of full-time dermatologists for the past 2 years, despite offering the second-highest rates of remuneration for services in the country, as shown in the National section of this report card.

2. **Limited access to phototherapy.** While the New Brunswick government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form of treatment for psoriasis —phototherapy—is limited. Phototherapy is presently available in 5 locations but for limited hours. Home phototherapy is not an insured service in the province, which puts this effective

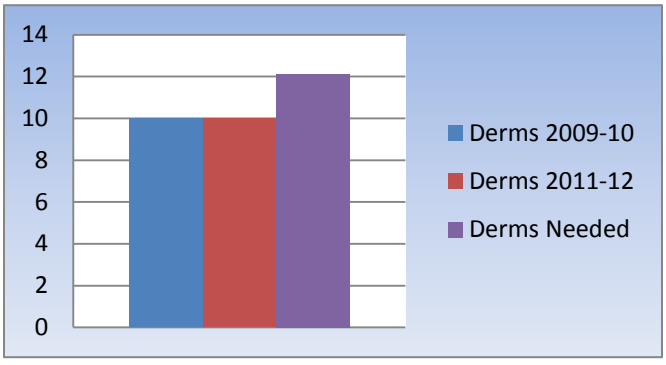
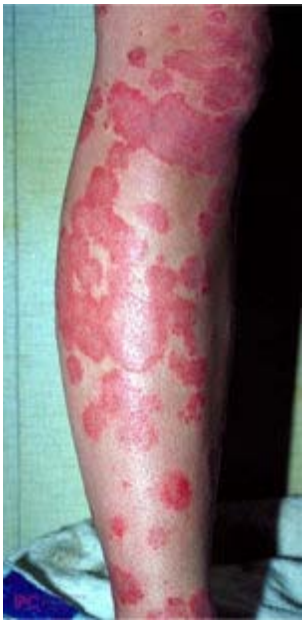


Figure 12. Change in Number of Dermatologists—NB

treatment out of reach for many New Brunswickers yet potentially burdens the health system with higher costs for clinics and drug therapies.

3. **Restricted access to medications.** While New Brunswick's public drug program lists a moderate number (76 per cent) of standard drugs for the treatment of psoriasis and psoriatic arthritis, less than 1 in 3 (31 per cent) listed drugs is available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time.



For psoriasis patients in New Brunswick to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). New Brunswick requires that a patient show an intolerance to or lack to response to both of these systemic treatments in addition to phototherapy before granting coverage for one of the newer biologics.

Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments. As noted above, it is difficult for patients to access phototherapy making this particular restriction to medications even more unreasonable.

Table 28. Performance of New Brunswick on access to medications

Measure	New Brunswick	Benchmark	Grade
Number of selected standard care drugs listed	69%	90%	Needs improvement
Unrestricted drugs (of listed)	27%	80%	Fail

Table 29. Funding status of medications to treat psoriasis in New Brunswick

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Full benefit	Not required
Dovobet (calcipotriol + betamethasone) ointment	Full Benefit	
Dovobet (calcipotriol + betamethasone) gel	Full Benefit	
Silkis (calcitriol cream)	Not a benefit	
Tazorac (tazarotene)	Not a benefit	
Neoral (cyclosporine)	Not a benefit	Covered for transplant patients only
Soriatane (acitretin)	Full benefit	Not required
Humira (adalimumab)	Special Authorization	Requests will be considered for treatment of patients with severe, debilitating chronic plaque psoriasis who meet all of the following criteria: o Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genital region; o Failure to respond to, contraindications to or intolerance to methotrexate and cyclosporine; o Failure to respond to, intolerance to or unable to access phototherapy
Enbrel (etanercept)		
Remicade (infliximab)		
Stelara (ustekinumab)		• Initial approval limited to 12 to16 weeks [depending on the biologic]. • Continuation of therapy beyond 12 to 16 weeks will be based on response. Patients not responding adequately at these time points should have treatment discontinued with no further treatment with the same agent recommended.

New Brunswick

Medication	Listing Status	Special Authorization Criteria
		• An adequate response is defined as either: o ≥75% reduction in the Psoriasis Area and Severity Index (PASI) score from when treatment started (PASI 75), or o ≥50% reduction in the PASI score (PASI 50) with a ≥5 point improvement in the Dermatology Life Quality Index (DLQI) from when treatment started, or o a quantitative reduction in BSA affected with qualitative consideration of specific regions such as face, hands, feet, or genital region. • Must be prescribed by a dermatologist • Concurrent use of >1 biologic will not be approved • Approval limited to a dose [varies by biologic], up to a year (if response criteria met at 12 to16 weeks)

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab)	Special Authorization	For the treatment of moderate to severe psoriatic arthritis in patients who: • Have at least three active and tender joints, and • Have not responded to an adequate trial of two DMARDs or have an intolerance or contraindication to DMARDs. • Must be prescribed by a rheumatologist or internist. • Initial approval will be for 4 x 50 mg doses in a 4 month period. • Requests for continuation of therapy must include information demonstrating clinical beneficial effects of the treatment. • Approvals for continuation of therapy will be for 12 x 50 mg doses annually with no dose escalation permitted. • Golimumab will not be reimbursed in combination with other anti-TNF agents.
Humira (adalimumab)	Special Authorization	For the treatment of active psoriatic arthritis in patients who: o Have at least three active and tender joints, and o Have not responded to an adequate trial of two DMARDs or have an intolerance or contraindication to DMARDs. • Must be prescribed by a rheumatologist. • The number of doses is limited to twenty-six 40 mg doses per year with no dose escalation permitted. • Should not be used in combination with other tumor necrosis factor (TNF) antagonists.
Enbrel (etanercept)	Special Authorization	• For the treatment of patients with active psoriatic arthritis who have not responded to an adequate trial with two disease modifying antirheumatic drugs (DMARDs) or who have an intolerance or contraindication to DMARDs. • Must be prescribed by a rheumatologist.
Remicade (infliximab)	Not a benefit	Not a benefit for psoriatic arthritis

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of New Brunswick to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

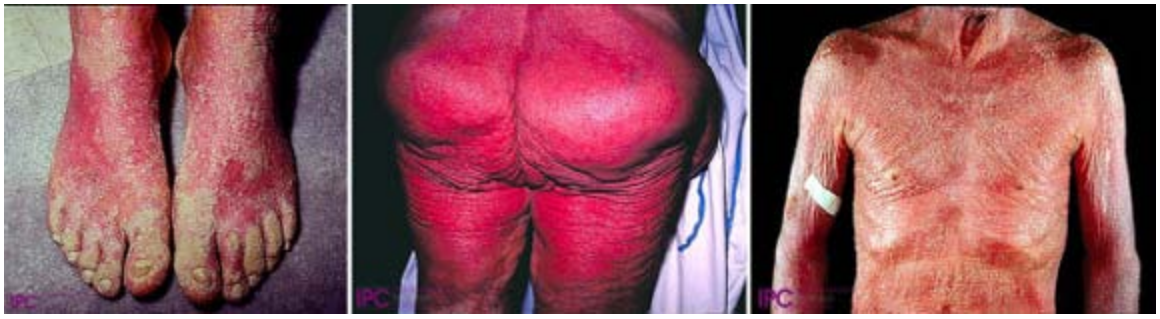
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include developing a plan to achieve a minimum ratio of 1 full-time medical dermatologist for every 62,500 people by training 2 additional dermatologists;

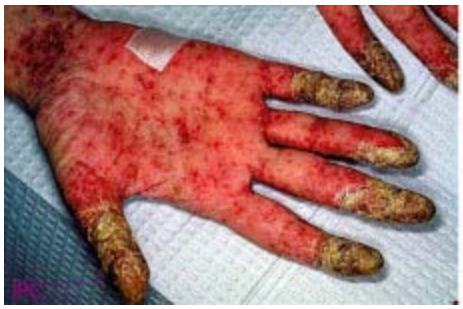
2. Improve access to phototherapy

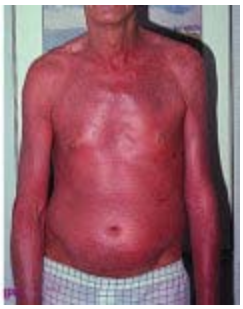
Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







Access to:	Grade
Dermatological care	Fail
Phototherapy	Fail
Medications	Fail

Prince Edward Island

Key issues

1. Patients in Atlantic Canada experience **long wait times** for routine appointments with a dermatologist – on average 23 weeks, the longest in Canada and very much longer than the benchmark of 5 weeks. Having no dermatologist on the island (although family practitioners provide limited dermatology services) **patients must travel outside the province for consultation with a specialist**. According to the Royal College of Physicians and Surgeons of Canada, the recommended ratio of dermatologists to population is 1:62,500. By this standard, Prince Edward Island should have 2 full-time dermatologists. Remuneration rates for dermatology services are the highest in the country, as shown in the National section of this report card, which may help in recruiting and retaining dermatologists.

2. **Access to phototherapy.** There are **no facilities** in Prince Edward Island for psoriasis patients to receive a primary form of treatment for their disease —phototherapy. Furthermore, home phototherapy is not an insured service in the province.

3. **Access to medications.** Prince Edward Island's public drug program lists the **smallest number** (53 per cent) of standard drugs for the treatment of psoriasis and psoriatic arthritis in Canada. Notably it is the only province or territory to **not list biological drugs**, which can provide outstanding efficacy to patients with moderate to severe psoriasis and psoriatic arthritis. Additionally, only 33 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barrier to access and waste scarce dermatologist time.

Table 30. Performance of Prince Edward Island on access to medications

Measure	Prince Edward Island	Benchmark	Grade
Number of selected standard care drugs listed	44%	90%	Fail
Unrestricted drugs (of listed)	29%	80%	Fail

Table 31. Funding status of medications to treat psoriasis in Prince Edward Island

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Full benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Not a benefit	
Dovobet (calcipotriol + betamethasone) gel	Special Authorization	For the treatment of patients with scalp psoriasis: Who have failed a trial with a topical steroid alone AND; Who have failed a trial with a topical steroid and calcipotriol together.
Silkis (calcitriol cream)	Not a benefit	
Tazorac (tazarotene)	Not a benefit	
Neoral (cyclosporine)	Not a benefit	Covered for transplant patients only
Soriatane (acitretin)	Special Authorization	For the treatment of severe intractable psoriasis, Darier's Disease, ichthyosiform dermatoses, palmoplantar pustulosis and other disorders of keratinization.

Medication	Listing Status	Special Authorization Criteria
Humira (adalimumab)	Not a benefit	Not a benefit for psoriasis
Enbrel (etanercept)	Not a benefit	Not a benefit for psoriasis
Remicade (infliximab)	Not a benefit	Not a benefit for psoriasis
Stelara (ustekinumab)	Not a benefit	Not a benefit for psoriasis

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab)	Special Authorization	Golimumab, Syringe, 50mg/0.5ml; auto-injector, 50mg/0.5ml (Simponi-MSD) Approvals will be for a maximum adult dose of 50mcg once monthly. Adalimumab, kit, 40mg/0.8ml (Humira-ABB) Approvals will be for a maximum adult dose of 40mg every two weeks. Etanercept, pre-filled syringe, 50mg/ml; injection powder, 25mg/kit (Enbrel-AMG) Approvals will be for a maximum adult dose of 50mg per week or 25 mg twice weekly.
Humira (adalimumab)		
Enbrel (etanercept)		
Remicade (infliximab)	Not a benefit	Not a benefit for psoriatic arthritis

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids

1. methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Prince Edward Island to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

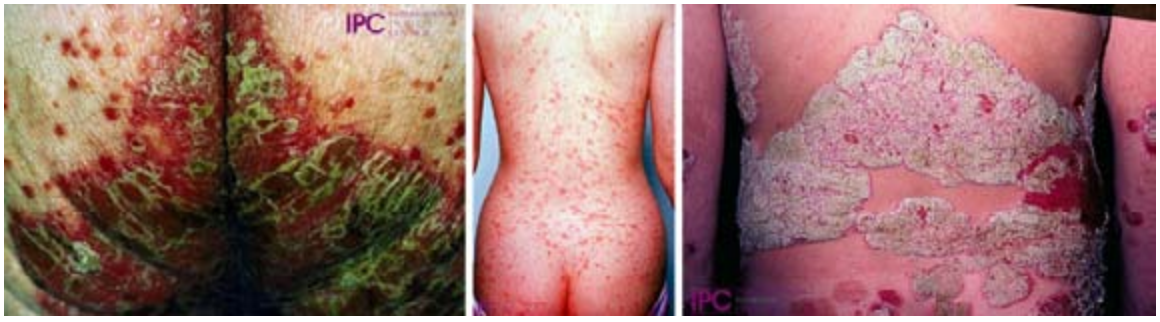
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include developing a plan to train 2 full-time dermatologists;

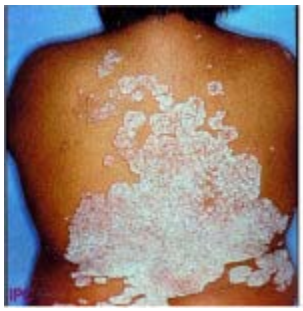
2. Improve access to phototherapy

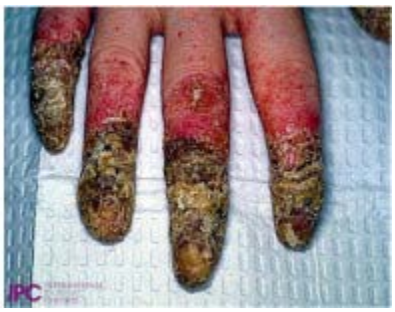
Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







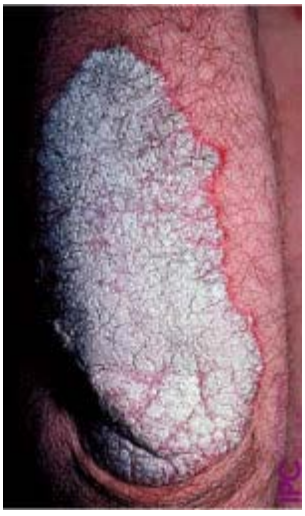
Access to:	Grade
Dermatological care	Needs improvement
Phototherapy	Fail
Medications	Fail

Nova Scotia

Key issues

1. Patients in Atlantic Canada experience **long wait times** for routine appointments with a dermatologist – on average 23 weeks, the longest in Canada and very much longer than the benchmark of 5 weeks. It is unclear why wait times are so long, considering the number of dermatologists practising in Nova Scotia. Presently there is 1 full-time dermatologist for every 63,000 population, close to the 1:62,500 ratio recommended by the Royal College of Physicians and Surgeons of Canada. (The number of full-time dermatologists has not changed over the past 2 years.) However, dermatologists practise in major urban centres and may not be accessible to rural populations.

2. **Lack of access to phototherapy.** While the Nova Scotia government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form of treatment for psoriasis — phototherapy — is difficult to access. There is currently only 1 phototherapy clinic for every 135,000 residents — twice as low as the 1:62,500 ratio recommended by CAPP. Home phototherapy is not an insured service in the province for those who cannot access a clinic. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative.



3. The Nova Scotia government includes a moderate number (76 per cent) of standard drugs for the treatment of psoriasis and psoriatic arthritis on its public drug program formulary.

However, Nova Scotia is the most restrictive province in Canada. Only 23 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time.

For psoriasis patients in Nova Scotia to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). Nova Scotia requires that a patient show an inability to tolerate or lack of response to both of these systemic treatments in addition to phototherapy before granting coverage for one of the newer biologics. Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments. As noted above, it is difficult for patients to access phototherapy making this particular restriction to medications even more unreasonable.

Table 32 Performance of Nova Scotia on access to medications

Measure	Nova Scotia	Benchmark	Grade
Number of selected standard care drugs listed	94%	90%	Pass
Unrestricted drugs (of listed)	27%	80%	Fail

Table 33 Funding status of medications to treat psoriasis in Nova Scotia

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Exception Status	For the treatment of psoriasis when conventional therapies have been ineffective or inappropriate
Dovobet (calcipotriol + betamethasone) ointment	Open benefit	Not applicable
Dovobet (calcipotriol	Exception	For the treatment of scalp psoriasis after:

Medication	Listing Status	Special Authorization Criteria
+ betamethasone) gel	Status	· failure of a topical steroid · the use of a topical steroid and calcipotriol together as single agents
Silkis (calcitriol cream)	Open benefit	Not applicable
Tazorac (tazarotene)	Exception Status	For use in psoriasis therapy when conventional therapies have been ineffective or inappropriate
Neoral (cyclosporine)	Exception Status	For the treatment of severe psoriasis
Soriatane (acitretin)	Open benefit	Not applicable
Humira (adalimumab) **Enbrel (etanercept)** **Remicade (infliximab)**	Exception Status	For patients with severe, debilitating chronic plaque psoriasis (PsO) who meet all of the following criteria: · Body Surface Area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genital region · failure to respond to, contraindications to or intolerant to methotrexate and cyclosporine · failure to respond to, intolerant to or unable to access phototherapy - written request of a dermatologist or prescriber with a specialty in dermatology - continued coverage is dependent on evidence of improvement, specifically: · > 75% reduction in the Psoriasis Area and Severity Index (PASI) score, or - > 50% reduction in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index), or - significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals - concurrent use of biologics not approved **Initial duration and maximum dosage approved:** **Adalimumab** - initial approval for a maximum of 16 weeks - maximum dosage for ongoing coverage is 40mg every two weeks **Etanercept** - initial approval for a maximum of 12 weeks - maximum dosage approved: 50mg biweekly for the initial 12 weeks then 50mg weekly thereafter **Infliximab** - initial approval for a maximum of 12 weeks - dosage restricted to infliximab 5mg/kg 0, 2 and 6 weeks then every 8 weeks

Medication	Listing Status	Special Authorization Criteria
Stelara (ustekinumab)	Exception Status	For patients with severe, debilitating chronic plaque psoriasis (PsO) who meet all of the following criteria: · Body Surface Area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals · failure to respond to, contraindication to or intolerant to methotrexate and cyclosporine · failure to respond to, intolerant to or unable to access phototherapy - written request of a dermatologist or prescriber with a specialty in dermatology - continued coverage is dependent on evidence of improvement, specifically: · > 75% reduction in the Psoriasis Area and Severity Index (PASI) score, *or* · > 50% reduction in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index), *or* · significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals - concurrent use of biologics not approved - initial approval for a maximum of 16 weeks - dosage restricted to 45mg at 0, 4 and 16 weeks, response must be assessed prior to fourth dose - maintenance dosing every 12 weeks

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab) **Humira (adalimumab)**	Exception Status	For patients with active psoriatic arthritis who meet all of the following: - have at least three active and tender joints - have not responded to an adequate trial with two DMARDs or have an intolerance or contraindication to DMARDs - not used in combination with other TNF antagonists - written request of a rheumatologist or prescriber with a specialty in rheumatology - after initial coverage period, can be reassessed for yearly coverage dependent on patient achieving an improvement in symptoms of at least 20% Initial Coverage Duration and Maximum Dosage approved: Adalimumab - initial period 3 months, maximum dose of 40mg every two weeks **Golimumab** - initial period 3 months, maximum dose 50mg per month _____ *1 An adequate trial is 5 months for IM gold, 6 months for penicillamine, 4 months for hydroxychloroquine and 3 months for all other traditional DMARDs as well as leflunomide, infliximab and etanercept.* *2 Traditional agents include methotrexate, IM gold, sulfasalazine, hydroxychloroquine, azathioprine, chloroquine, penicillamine and cyclosporine.* *Please note that the concurrent use of anti-TNF agents will not be approved.
Enbrel (etanercept)	Exception Status	For the treatment of active psoriatic arthritis in patients who have not responded to an adequate trial with two DMARDs or who have an intolerance or contraindication to DMARDs - written request of a rheumatologist or prescriber with a specialty in rheumatology - coverage will be approved initially for 3 months. Can be reassessed for yearly coverage dependent on patient achieving an improvement in symptoms of at least 20%
Remicade (infliximab)	Not a benefit	Not a benefit for psoriatic arthritis

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Nova Scotia to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

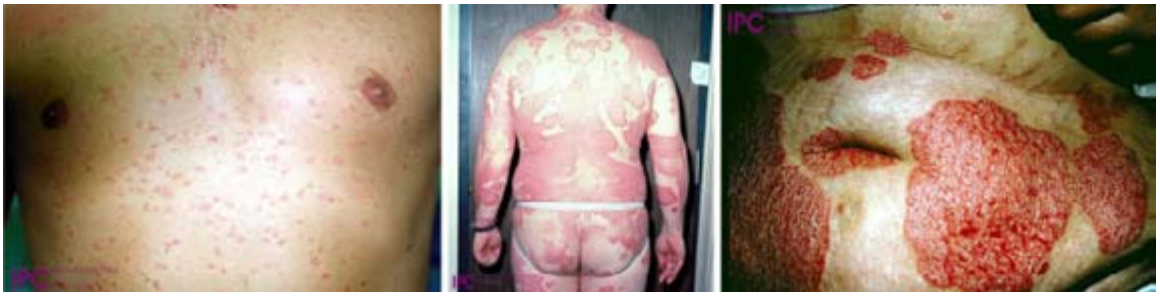
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include determining the root cause of long wait times;

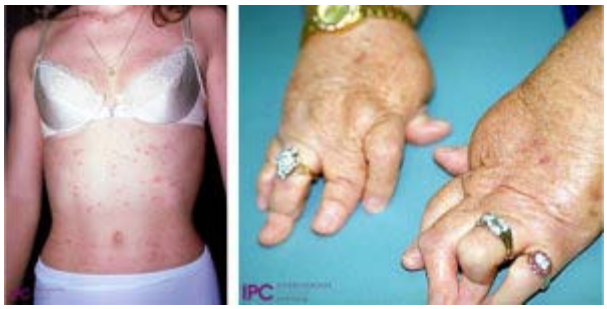
2. Improve access to phototherapy

Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.





Access to:	Grade
Dermatological care	Needs improvement
Phototherapy	Fail
Medications	Fail

Newfoundland & Labrador

Key issues

1. Patients in Atlantic Canada experience **long wait times** for routine appointments with a dermatologist – on average 23 weeks, the longest in Canada and very much longer than the benchmark of 5 weeks. The province deserves credit for having 1 full-time dermatologist for every 47,900 population — greater than the 1:62,500 ratio recommended by the Royal College of Physicians and Surgeons of Canada — despite having 2 fewer full-time dermatologists during the past 2 years. The province deserves praise for implementing Return of Service contracts with residents trained outside the province and it appears that this strategy has been successful. However, dermatologists practise in urban areas and rural populations may not have access to their services.

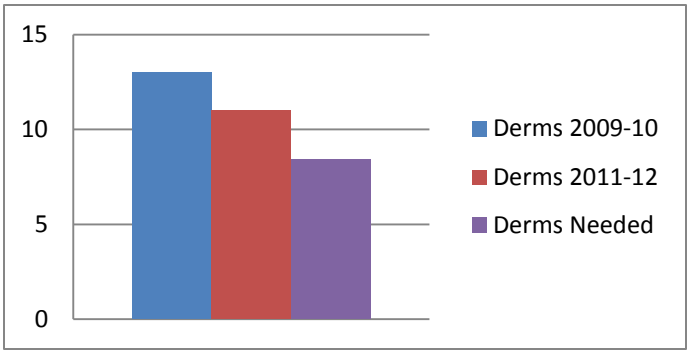
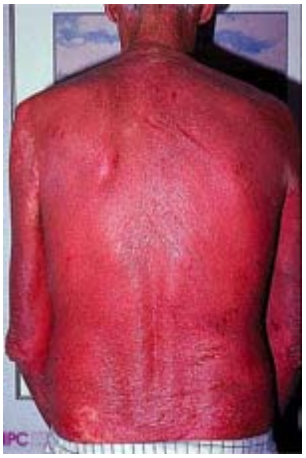


Figure 13. Changes in Number of Dermatologists—NL

2. **Lack of access to phototherapy.** While the Newfoundland & Labrador government has succeeded in providing specialized dermatology treatments in tertiary care centres, a primary form of treatment for psoriasis —phototherapy—is difficult for most patients to access. There is currently only 1 phototherapy clinic in the province, beyond

commuting distance for people living outside St. John's. The lack of phototherapy clinics may be due to the very low rate of remuneration for providing these services which, as shown in the National section of this report card, are the lowest in the country. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.

3. **Restricted Access to Medications.** Newfoundland & Labrador's public drug program lists a moderate number (82 per cent) of standard drugs for the treatment of psoriasis and psoriatic arthritis, however only 29 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time.



In order for psoriasis patients to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). Newfoundland and Labrador also requires that a patient show an inability to tolerate or lack of response to both of these systemic treatments in addition to phototherapy before granting coverage for one of the newer biologics. Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments. As noted above, it is difficult for patients to access phototherapy making this particular restriction to medications even more unreasonable.

Table 34. Performance of Newfoundland & Labrador on access to medications

Measure	Newfoundland & Labrador	Benchmark	Grade
Number of selected standard care drugs listed	81%	90%	Pass
Unrestricted drugs (of listed)	23%	80%	Fail

Table 35. Funding status of medications to treat psoriasis in Newfoundland & Labrador

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Open benefit	NB: Scalp solution is Special Authorization
Dovobet (calcipotriol + betamethasone) ointment	Not a benefit	
Dovobet (calcipotriol + betamethasone) gel	Special Authorization	For the treatment of scalp psoriasis in patients: Who have failed a trial with a topical steroid alone AND Who have failed a trial with a topical steroid AND calcipotriol together. Coverage will be provided for up to 4 weeks. If recurrence takes place after discontinuation, treatment may be reinstituted.
Silkis (calcitriol cream)	Not a benefit	
Tazorac (tazarotene)	Special Authorization	For use in psoriasis therapy when conventional therapies (high potency steroids) have been ineffective or are inappropriate.
Neoral (cyclosporine)	Special Authorization	Upon request from a dermatologist for severe psoriasis unresponsive to conventional therapies
Soriatane (acitretin)	Open benefit	Not applicable
Remicade (infliximab) **Humira (adalimumab)** **Enbrel (etanercept)** **Stelara (ustekinumab)**	Special Authorization	For patients with severe debilitating psoriasis who meet all of the following criteria: Body surface involvement of greater than 10% and/or significant involvement of the face, hands, feet or genital region. Failure to respond to, contraindications to, or intolerant to methotrexate and cyclosporine. Failure to respond to, intolerant to or unable to access phototherapy. Coverage will be approved initially for 3 to 4 months [depending on the biologic]. Can be reassessed for yearly coverage dependent on the patient achieving a response of greater than or equal to 75% reduction in PASI (Psoriasis Area Severity Index) score or greater than 50% reduction in PASI with a greater than or

Medication	Listing Status	Special Authorization Criteria
		equal to 5 point improvement in DLQI (Dermatology Life Quality Index) or a quantitative reduction in BSA (Body Surface Area) affecting the face, hands, feet or genital region. Written request from a dermatologist. Dosage restricted [according to the biologic]. Coverage will not be provided for two biologicals concurrently.

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab)	Special Authorization	For patients with active psoriatic arthritis who meet **all** of the following criteria: Have at least three active and tender joints. Failure to respond to non-steroidal anti-inflammatory agents **and,** failure to respond to an adequate trial with two DMARD's (e.g., sulfasalazine, methotrexate, leflunomide, cyclosporine) or contraindications to, or intolerance of these agents. Coverage will be approved initially for 3 months. Can be reassessed for yearly coverage dependent on achieving improvement in symptoms of at least 20% (*20% improvement in the American College of Rheumatology response criteria (ACR 20) or response using the Psoriatic Arthritis Response Criteria).* Dosage restricted to a maximum of 40mg every 2 weeks. Not used in combination with other TNF antagonists. Written request from a rheumatologist only.
Humira (adalimumab)		
Enbrel (etanercept)	Special Authorization	For the treatment of psoriatic arthritis in patients who have not responded to an adequate trial of two DMARDs or have had intolerance or contraindication to DMARDs. Traditional agents include methotrexate, IM gold, sulfasalazine, hydroxychloroquine, azathioprine, chloroquine, D-penicillamine and cyclosporine.
Remicade (infliximab)	Not a benefit	Not a benefit for psoriatic arthritis indication

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs

- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Newfoundland & Labrador to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

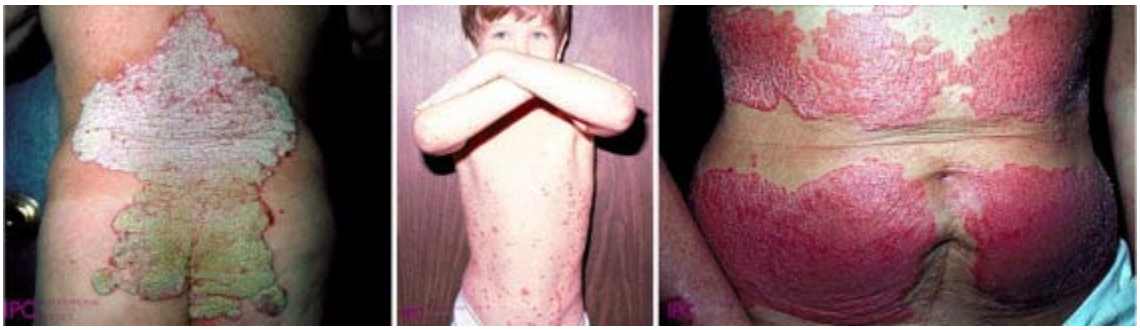
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include continuing with the successful Return of Service contracts and developing a plan to expand outreach services to rural areas.

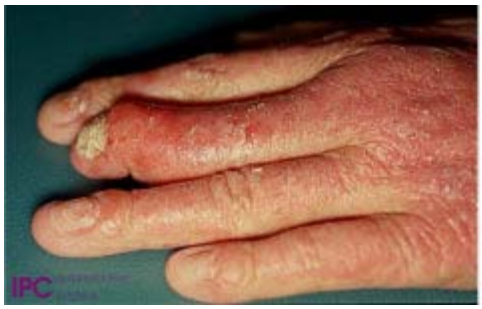
2. Improve access to phototherapy

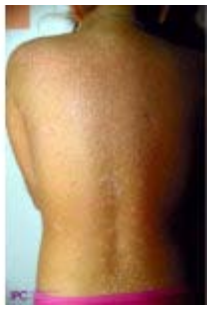
Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications.

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







Access to:	Grade
Dermatological care	Fail
Phototherapy	Fail
Medications	Fail

Yukon Territory

Key issues

1. The degree of **access to dermatologist**s in Yukon is unknown. At least one dermatologist from outside the territory maintains an office in the Whitehorse General Hospital and two dermatologists from British Columbia provide teledermatology services to patients in Yukon. There are no data on wait times in the territory. If patients travel to British Columbia for a consultation, they must wait an average of 10 weeks — much longer than the benchmark of 5 weeks. The ratio recommended by the Royal College of Physicians and Surgeons of Canada of 1:62,500 population suggests that at least a half-time dermatologist is needed.

2. **Lack of access to phototherapy.** Specialized dermatology treatments, including a primary form of treatment for psoriasis —phototherapy—are **not available** in Yukon. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.

3. **Restricted access to medications.** While Yukon's public drug program lists some (76 per cent) standard drugs for the treatment of psoriasis and psoriatic arthritis, only 46 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time. Access to newer biologic treatments is severely restricted.

Table 36. Performance of Yukon on access to medications

Measure	Yukon	Benchmark	Grade
Number of selected standard care drugs listed	63%	90%	Needs improvement
Unrestricted drugs (of listed)	50%	80%	Fail

Table 37. Funding status of medications to treat psoriasis in Yukon

Psoriasis drugs.

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Full benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Full benefit	None required
Dovobet (calcipotriol + betamethasone) gel	Not a benefit	
Silkis (calcitriol cream)	Not a benefit	
Tazorac (tazarotene)	Full benefit	None required
Neoral (cyclosporine)	Full benefit	None required
Soriatane (acitretin)	Exception drug status	For treatment of severe psoriasis on recommendation of Dermatologist.
Humira (adalimumab)	Exception drug status	Criteria for psoriasis not stated
Enbrel (etanercept)	Not a benefit	Not a benefit for psoriasis
Remicade	Not a benefit	Not a benefit for psoriasis

Medication	Listing Status	Special Authorization Criteria
(infliximab)		
Stelara (ustekinumab)	Not a benefit	

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab)	Not a benefit	
Humira (adalimumab)	Exception drug status	On recommendation by Rheumatologist. Request reviewed on case-by-case basis. For patients with active rheumatoid arthritis who have failed on at least 2 DMARDS. Treatment should be combined with an immunosuppressant.
Enbrel (etanercept)	Exception drug status	On recommendation of a Rheumatologist. Requests reviewed on case-by-case basis.
Remicade (infliximab)	Exception drug status	On recommendation by Rheumatologist. Request reviewed on case-by-case basis. For patients with active rheumatoid arthritis who have failed on at least 2 DMARDS. Treatment should be combined with an immunosuppressant.

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Yukon to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

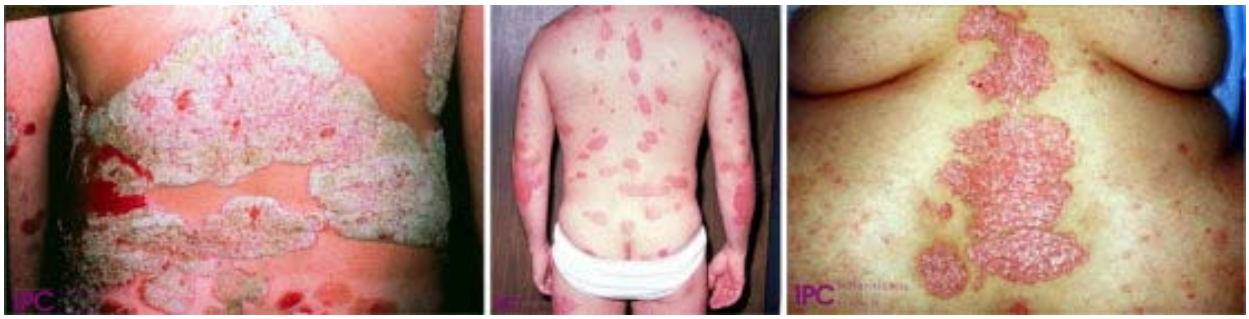
Determine wait times for routine dermatology consultations and, if needed, reduce to 5 weeks within the next 3 years. Strategies may include developing a plan to recruit a half-time dermatologist;

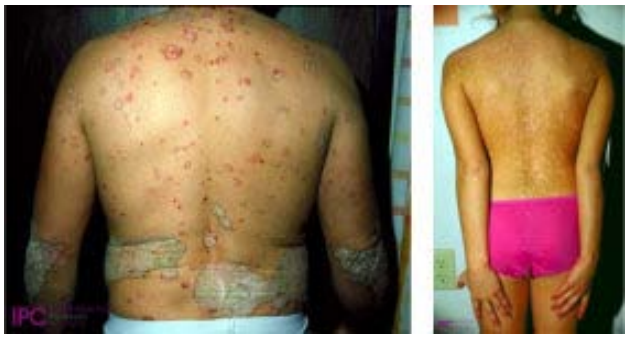
2. Improve access to phototherapy

Ensure that every psoriasis patient in the territory has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.





Access to:	Grade
Dermatological care	Needs improvement
Phototherapy	Needs improvement
Medications	Fail

Northwest Territories

Key issues

1. The Government of Northwest Territories deserves credit for providing generally **good access to dermatological care**. There is one dermatologist located in the Northwest Territories, achieving the ratio of 1 full-time dermatologist for every 62,500 population recommended by the Royal College of Physicians and Surgeons of Canada. Outreach services are provided throughout the territory from the Stanton Territorial Hospital and by teledermatology from the University of Alberta in Edmonton. However, given that the population is spread out over the territories and limited access in remote areas is an issue, this area does need improvement. No data are available on wait times within the territory. Patients who travel to Alberta for a consultation, however, experience long wait times for routine appointments with a dermatologist – on average 8 weeks, longer than the benchmark of 5 weeks.
2. **Lack of access to phototherapy.** There is 1 phototherapy clinic in Northwest Territories, located in Yellowknife. Residents living outside the capital have very limited access to this effective form of treatment for psoriasis. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.

3. **Restricted access to medications.** The Northwest Territories' public drug program lists a relatively **small number** (65 per cent) of standard drugs for the treatment of psoriasis and psoriatic arthritis, and only 55 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time.

For psoriasis patients in Northwest Territories to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). Northwest Territories requires that a patient show an inability to tolerate or lack of response to both of these systemic treatments in addition to phototherapy before granting coverage for one of the newer biologics. Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments. As noted above, it is difficult for patients to access phototherapy making this particular restriction to medications even more unreasonable.

Table 38. Performance of Northwest Territories on access to medications

Measure	Northwest Territories	Benchmark	Grade
Number of selected standard care drugs listed	69%	90%	Needs improvement
Unrestricted drugs (of listed)	55%	80%	Fail

Table 39. Funding status of medications to treat psoriasis in Northwest Territories

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Open Benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Open Benefit	None required
Dovobet (calcipotriol + betamethasone) gel	Open Benefit	None required
Silkis (calcitriol cream)	Non-Benefit	
Tazorac (tazarotene)	Open Benefit	None required
Neoral (cyclosporine)	Non-Benefit	Not a benefit for psoriasis indication
Soriatane (acitretin)	Open Benefit	Soriatane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.
Humira (adalimumab)	Limited Use (prior approval required)	For the treatment of patients with moderate to severe psoriasis who meet all of the following criteria: •Body surface area involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region AND •Intolerance or lack of response to methotrexate AND cyclosporine OR •A contraindication to methotrexate and/or cyclosporine AND •Intolerance or lack of response to phototherapy OR •Inability to access phototherapy Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI).

Medication	Listing Status	Special Authorization Criteria
Enbrel (etanercept)	Non-Benefit	Not a benefit for psoriasis indication
Remicade (infliximab)	Non-Benefit	Not a benefit for psoriasis indication
Stelara (ustekinumab)	Limited Use (prior approval required)	For the treatment of moderate to severe psoriasis in patients who meet the following criteria: a. - Body surface area involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region and b. - Intolerance or lack of response to methotrexate and cyclosporine or c. - A contraindication to methotrexate and/or cyclosporine and d. - Intolerance or lack of response to phototherapy or e. - Inability to access phototherapy Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI).

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab) Humira (adalimumab) Enbrel (etanercept)	Limited Use (prior approval required)	Criteria for initial one year coverage for a maximum [specified dosage schedule]: 1. Prescribed by a rheumatologist, AND 2. Patient has had a tuberculin skin test performed For the treatment of moderate to severe psoriatic arthritis with at least two of the following: •five or more swollen joints •if less than five swollen joints, at least one joint proximal to, or including wrist or ankle •more than one joint with erosion on imaging study •dactylitis of two or more digits •tenosynovitis refractory to oral NSAIDs and steroid injections •enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon) •inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4 •daily use of corticosteroids •use of opioids > 12 hours per day for pain resulting from

Medication	Listing Status	Special Authorization Criteria
		inflammation Patient is refractory to: •NSAIDs and •methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks PLUS a minimum of one of the following: •leflunomide: 20mg daily for 10 weeks OR •gold: weekly injections for 20 weeks OR •cyclosporine: 2-5 mg/kg/day for 12 weeks OR •sulfasalazine at least 2g daily for 3 months
Remicade (infliximab)	Non-Benefit	Not a benefit for psoriatic arthritis indication

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Northwest Territories to achieve the following goals in collaboration with dermatology professionals and patients.

1. Continue to provide access to dermatological care

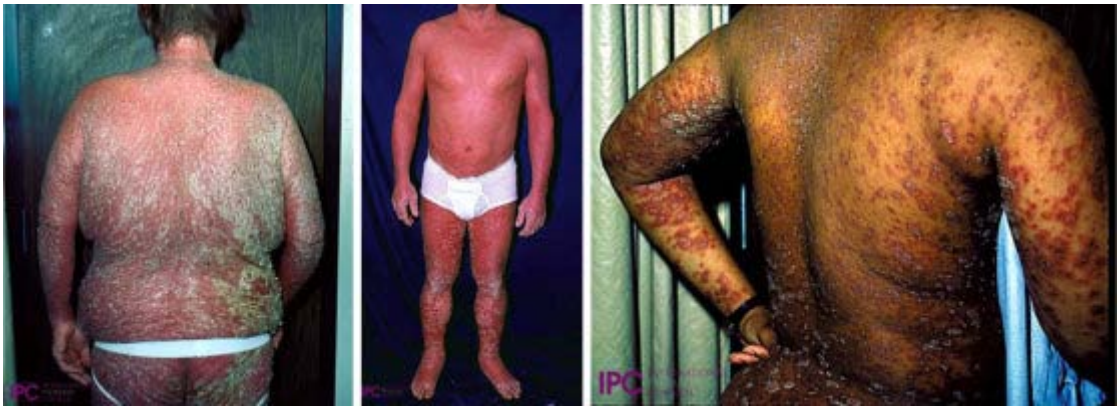
a. Retain the current dermatologist and continue to provide outreach services;

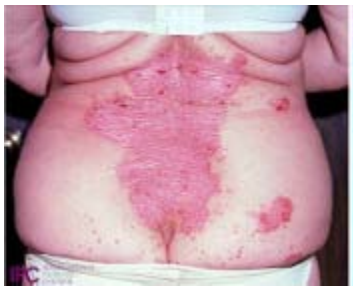
2. Improve access to phototherapy

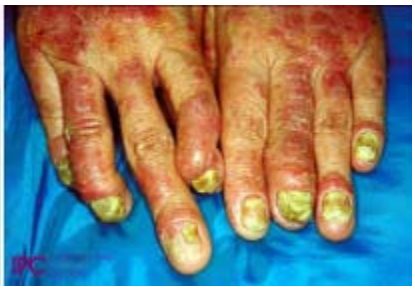
a. Ensure that every psoriasis patient in the territory has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

a. Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.







Access to:	Grade
Dermatological care	Fail
Phototherapy	Fail
Medications	Fail

Nunavut

Key issues

1. There are no dermatologists located in Nunavut. Outreach dermatology services are provided through the Qikiqtani General Hospital in Iqaluit and by teledermatology from the University of Ottawa. Patients who travel to Ontario for specialist consultation experience **long wait times** for routine appointments with a dermatologist. On average they must wait an average of 12 weeks, much longer than the benchmark of 5 weeks. The ratio recommended by the Royal College of Physicians and Surgeons of Canada of 1:62,500 population would suggest that at least a part-time dermatologist is needed in Nunavut.

2. **Lack of access to phototherapy.** Specialized dermatology treatments, including a primary form of treatment for psoriasis —phototherapy—are not available in Nunavut. Home phototherapy could potentially save health care dollars by avoiding treatment with biological agents, which are comparatively costly and are the only alternative, yet this is not an insured service.

3. **Lack of access to medications.** Nunavut's public drug program lists a **small number** (65 per cent) of standard drugs for the treatment of psoriasis and psoriatic arthritis, and only 55 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time.

For psoriasis patients in Nunavut to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). Nunavut requires that a patient show an inability to tolerate or lack of response to both of these systemic treatments in addition to phototherapy before granting coverage for one of the newer biologics. Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments.

Table 40. Performance of Nunavut on access to medications

Measure	Nunavut	Benchmark	Grade
Number of selected standard care drugs listed	69%	90%	Needs improvement
Unrestricted drugs (of listed)	55%	80%	Fail

Table 41. Funding status of medications to treat psoriasis in Nunavut

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Open Benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Open Benefit	None required
Dovobet (calcipotriol + betamethasone) gel	Open Benefit	None required
Silkis (calcitriol cream)	Non-Benefit	

Medication	Listing Status	Special Authorization Criteria
Tazorac (tazarotene)	Open Benefit	None required
Neoral (cyclosporine)	Non-Benefit	Not a benefit for psoriasis indication
Soriatane (acitretin)	Open Benefit	Soriatane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.
Humira (adalimumab)	Limited Use (prior approval required)	For the treatment of patients with moderate to severe psoriasis who meet all of the following criteria: •Body surface area involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region AND •Intolerance or lack of response to methotrexate AND cyclosporine OR •A contraindication to methotrexate and/or cyclosporine AND •Intolerance or lack of response to phototherapy OR •Inability to access phototherapy Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI).
Enbrel (etanercept)	Non-Benefit	Not a benefit for psoriasis indication
Remicade (infliximab)	Non-Benefit	Not a benefit for psoriasis indication
Stelara (ustekinumab)	Limited Use (prior approval required)	For the treatment of moderate to severe psoriasis in patients who meet the following criteria: a. - Body surface area involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region and b. - Intolerance or lack of response to methotrexate and cyclosporine or

Medication	Listing Status	Special Authorization Criteria
		c. - A contraindication to methotrexate and/or cyclosporine and d. - Intolerance or lack of response to phototherapy or e. - Inability to access phototherapy Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI).

Psoriatic arthritis drugs

Medication	**Listing Status**	**Special Authorization Criteria**
Simponi (golimumab)	Limited Use (prior approval required)	Criteria for initial one year coverage for a maximum [specified dosage schedule]: 1. Prescribed by a rheumatologist, AND 2. Patient has had a tuberculin skin test performed For the treatment of moderate to severe psoriatic arthritis with at least two of the following: •five or more swollen joints •if less than five swollen joints, at least one joint proximal to, or including wrist or ankle •more than one joint with erosion on imaging study •dactylitis of two or more digits •tenosynovitis refractory to oral NSAIDs and steroid injections •enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon) •inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4 •daily use of corticosteroids •use of opioids > 12 hours per day for pain resulting from inflammation Patient is refractory to: •NSAIDs and •methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks PLUS a minimum of one of the following: •leflunomide: 20mg daily for 10 weeks OR •gold: weekly injections for 20 weeks OR •cyclosporine: 2-5 mg/kg/day for 12 weeks OR
Humira (adalimumab)		
Enbrel (etanercept)		

Medication	Listing Status	Special Authorization Criteria
		•sulfasalazine at least 2g daily for 3 months
Remicade (infliximab)	Non-Benefit	Not a benefit for psoriatic arthritis indication

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

The Canadian Association of Psoriasis Patients calls on the Government of Nunavut to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to dermatological care

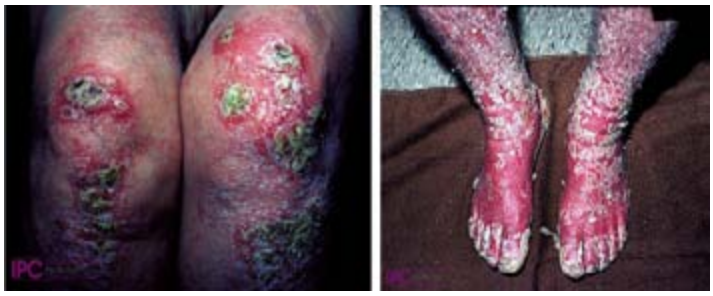
Reduce wait times for routine dermatology consultations to 5 weeks within the next 3 years. Strategies may include developing a plan to recruit a part-time dermatologist.

2. Improve access to phototherapy

Ensure that every psoriasis patient in the province has access to phototherapy by providing a phototherapy clinic in every publicly funded hospital and by including home phototherapy as an insured service for patients who cannot access a clinic.

3. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.



Access to:	Grade
Dermatological care	Not applicable
Phototherapy	Fail
Medications	Fail

Non-Insured Health Benefits Program

Key issues

1. **Lack of access to phototherapy.** Home phototherapy is not an insured service under the Non-Insured Health Benefits (NIHB) program. This lack of coverage denies access by many First Nations and Inuit psoriasis patients to a clinically effective form of therapy which may reduce costs elsewhere in the health system by avoiding clinic visits and potentially also costly drug therapies.
2. The NIHB program lists a **small number** (65 per cent) of standard drugs for the treatment of psoriasis and psoriatic arthritis, and only 55 per cent of listed drugs are available to all patients without the **unreasonable and time-consuming restrictions** which pose barriers to access and waste scarce dermatologist time.
3. For NIHB psoriasis patients to be prescribed newer biological treatments, they must first try and fail on three prior treatments: phototherapy, methotrexate and cyclosporine (itself a Limited Use medication). Both of these drugs have toxicities that some patients are unable to withstand and have a limited duration of use. Since almost all patients with severe psoriasis will eventually be candidates for treatment with a biologic drug, it raises the question of why governments force skin patients to undergo these unpleasant and potentially dangerous protocols before being allowed access to newer and potentially more effective treatments.

Table 42. Performance of NIHB on access to medications

Measure	NIHB	Benchmark	Grade
Number of selected standard care drugs listed	69%	90%	Needs improvement
Unrestricted drugs (of listed)	55%	80%	Fail

Table 43. Funding status of medications to treat psoriasis by Non-Insured Health Benefits Program

Psoriasis drugs

Medication	Listing Status	Special Authorization Criteria
Dovonex (calcipotriol)	Open Benefit	None required
Dovobet (calcipotriol + betamethasone) ointment	Open Benefit	None required
Dovobet (calcipotriol + betamethasone) gel	Open Benefit	None required
Silkis (calcitriol cream)	Non-Benefit	
Tazorac (tazarotene)	Open Benefit	None required
Neoral (cyclosporine)	Non-Benefit	Not a benefit for psoriasis indication
Soriatane (acitretin)	Open Benefit	Soriatane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.
Humira (adalimumab)	Limited Use (prior approval required)	For the treatment of patients with moderate to severe psoriasis who meet all of the following criteria: •Body surface area involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region

Medication	Listing Status	Special Authorization Criteria
		AND •Intolerance or lack of response to methotrexate AND cyclosporine OR •A contraindication to methotrexate and/or cyclosporine AND •Intolerance or lack of response to phototherapy OR •Inability to access phototherapy Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI).
Enbrel (etanercept)	Non-Benefit	Not a benefit for psoriasis indication
Remicade (infliximab)	Non-Benefit	Not a benefit for psoriasis indication
Stelara (ustekinumab)	Limited Use (prior approval required)	For the treatment of moderate to severe psoriasis in patients who meet the following criteria: a. - Body surface area involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region and b. - Intolerance or lack of response to methotrexate and cyclosporine or c. - A contraindication to methotrexate and/or cyclosporine and d. - Intolerance or lack of response to phototherapy or e. - Inability to access phototherapy Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI).

Psoriatic arthritis drugs

Medication	Listing Status	Special Authorization Criteria
Simponi (golimumab)	Limited Use (prior approval required)	Criteria for initial one year coverage for a maximum [specified dosage schedule]: 1. Prescribed by a rheumatologist, AND 2. Patient has had a tuberculin skin test performed For the treatment of moderate to severe psoriatic arthritis with at least two of the following: •five or more swollen joints
Humira (adalimumab)		
Enbrel (etanercept)		

		•if less than five swollen joints, at least one joint proximal to, or including wrist or ankle •more than one joint with erosion on imaging study •dactylitis of two or more digits •tenosynovitis refractory to oral NSAIDs and steroid injections •enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon) •inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4 •daily use of corticosteroids •use of opioids > 12 hours per day for pain resulting from inflammation Patient is refractory to: •NSAIDs and •methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks PLUS a minimum of one of the following: •leflunomide: 20mg daily for 10 weeks OR •gold: weekly injections for 20 weeks OR •cyclosporine: 2-5 mg/kg/day for 12 weeks OR •sulfasalazine at least 2g daily for 3 months
Remicade (infliximab)	Non-Benefit	Not a benefit for psoriatic arthritis indication

The following prescription medications also recommended for the treatment of psoriasis are funded in all provinces and territories:

- non-steroidal anti-inflammatory drugs
- corticosteroids
- methotrexate

Recommendations

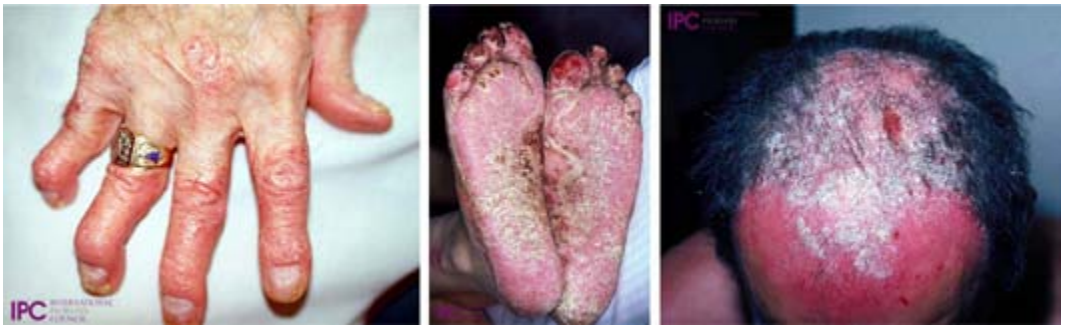
The Canadian Association of Psoriasis Patients calls on the Federal Government to achieve the following goals in collaboration with dermatology professionals and patients.

1. Improve access to phototherapy

Ensure that every psoriasis patient covered by NIHB has access to phototherapy by including home phototherapy as an insured service.

2. Improve access to medications

Fund *all* drugs deemed the standard of care without restrictions and without time-consuming application processes. Let the physicians together with their patients make the decisions about which therapies are appropriate.



Canadian Association of Psoriasis Patients
Association canadienne des patients atteints de psoriasis

CAPP information

The Canadian Association of Psoriasis Patients (CAPP) is a federally incorporated, non-profit patient support organization founded to serve the unique needs of Canadian psoriasis and psoriatic arthritis patients and their families. It is a subsidiary of the Canadian Skin Patient Alliance (CSPA), also a federally incorporated, non-profit patient support organization.

Our goal is to get this challenging and misunderstood skin condition out into the open, and to help us all as we manage our lives with psoriasis and psoriatic arthritis. We also want to make sure that anyone, anywhere in Canada can get access to the treatment they need.

CAPP Executive

Brooks Harvey, President

Jackie Dewar

Bernard Borkenhagen

Eva Borkenhagen

Paul-Francois Bourgault

Contact Information

Christine Janus, Executive Director

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In Partnership with CSPA

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