Prescriber Notification of Biosimilar Transition

PRESCRIBER
Name: Address: Phone: Fax

PATIENT INFORMATION
Name: DOB: Address: Health Card No. Phone:

Dear Dr._____,

Per the biosimilar policy, patients will transition from their reference biologic to a biosimilar version in order to maintain drug coverage through the Ontario Drug Benefit (ODB) program. The pharmacist recommends the following for this patient:

DRUG SELECTION			
STOP	**SWITCH TO**		
☐ Humira® (adalimumab)	☐ Abrilada® ☐ Hulio® ☐ Simlandi®	☐ Amgevita® ☐ Hyrimoz® ☐ Yuflyma®	☐ Hadlima® ☐ Idacio®
☐ Enbrel® (etanercept)	☐ Brenzys®	☐ Erelzi®	
☐ Copaxone® (glatiramer acetate)	☐ Glatect™		
☐ Remicade® (infliximab)	☐ Avsola®	☐ Inflectra®	☐ Renflexis®
☐ NovoRapid® (insulin aspart)	☐ Kirsty®	☐ Trurapi®	
☐ Lantus® (insulin glargine)	☐ Basaglar®	☐ Semglee®	
☐ Humalog® (insulin lispro)	☐ Admelog®		
☐ Rituxan® (rituximab)	☐ Riximyo®	☐ Ruxience™	☐ Truxima™

RECOMMENDATION	
STOP:	**SWITCH TO:**
Dose: Directions:	Dose: Directions: Quantity: Indication:

Check one of the following:

- ☐ Accept recommendation as written above
- ☐ Other (please advise below):

_____

_____

Please contact pharmacy at your earliest convenience. Thank you.

PHARMACIST	
Name:	Phone:
Pharmacy:	Fax:
Signature:	Date: