

ADALIMUMAB / GOLIMUMAB / INFLIXIMAB / TOFACITINIB / VEDOLIZUMAB for Ulcerative Colitis SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established
by Alberta government-sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other		
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER				
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER	

PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests																			
Diagnosis <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other (please specify) _____	Indicate requested drug¹ <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Abrilada</td> <td><input type="checkbox"/> Hadlima</td> <td><input type="checkbox"/> Inflectra</td> <td><input type="checkbox"/> Xeljanz</td> </tr> <tr> <td><input type="checkbox"/> Amgevita</td> <td><input type="checkbox"/> Hulio</td> <td><input type="checkbox"/> Renflexis</td> <td><input type="checkbox"/> Yuflyma</td> </tr> <tr> <td><input type="checkbox"/> Avsola</td> <td><input type="checkbox"/> Hyrimoz</td> <td><input type="checkbox"/> Simlandi</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Entyvio</td> <td><input type="checkbox"/> Idacio</td> <td><input type="checkbox"/> Simponi</td> <td></td> </tr> </table> <p><small>1. For Biosimilar Initiative Exception Requests, please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form</small></p>	<input type="checkbox"/> Abrilada	<input type="checkbox"/> Hadlima	<input type="checkbox"/> Inflectra	<input type="checkbox"/> Xeljanz	<input type="checkbox"/> Amgevita	<input type="checkbox"/> Hulio	<input type="checkbox"/> Renflexis	<input type="checkbox"/> Yuflyma	<input type="checkbox"/> Avsola	<input type="checkbox"/> Hyrimoz	<input type="checkbox"/> Simlandi		<input type="checkbox"/> Entyvio	<input type="checkbox"/> Idacio	<input type="checkbox"/> Simponi		Current weight (kg) _____	Dosage and frequency Date of last dose _____
<input type="checkbox"/> Abrilada	<input type="checkbox"/> Hadlima	<input type="checkbox"/> Inflectra	<input type="checkbox"/> Xeljanz																
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For patients new to coverage but currently maintained on the requested drug, please provide the treatment start date (YYYY-MM-DD) _____

Please provide reason if a switch to a different drug or change in dose is requested Note patients will not be permitted to switch back to a previously trialed drug if they were deemed unresponsive to therapy.

*Pre-treatment score Partial Mayo score _____ Date _____	Current score Partial Mayo score _____ Date _____
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*Requests for patients new to the requested drug and requests for patients new to coverage but currently maintained on the requested drug require pre-treatment scores. The Partial Mayo Score is a 9 point score consisting of 3 domains (same as full Mayo except endoscopic findings are eliminated). Please provide exact score(s).

For INITIAL requests - dose, duration and response are required for all medications previously utilized. If the following medications were not tried, please provide reason.

<input type="checkbox"/> Mesalamine
<input type="checkbox"/> Corticosteroids (please specify drug name)
<input type="checkbox"/> Other (please specify)

For requests to increase maintenance dosing to Infliximab 10 mg/kg, Golimumab 100 mg or Tofacitinib 10 mg

- 1) Is the patient already maintained on a dose of infliximab 10 mg/kg, golimumab 100 mg or tofacitinib 10 mg? Yes No
- 2) Has the patient had a *secondary loss of response* while on maintenance dosing with infliximab 5 mg/kg, golimumab 50 mg or tofacitinib 5 mg? Yes No (explain) _____
- 3) Provide the most recent partial Mayo score from when the patient was *responding* to maintenance dosing with infliximab 5 mg/kg, golimumab 50 mg or tofacitinib 5 mg _____ Date of Score _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta, T5J 3C5 FAX 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB, T5J 3C5.

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