

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

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

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		
DATE OF BIRTH: 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			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			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"/> Polyarticular Juvenile Idiopathic Arthritis <input type="checkbox"/> Other (please specify) _____	Current weight (kg) _____	Dosage Dosing frequency _____
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Please provide reason if a switch from a different biologic agent to abatacept is requested

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy

Current ACR Pedi 30 FLARE score (provide for ALL requests)	ACR Pedi 30 RESPONSE score at 16 to 20 weeks after first dose of previous abatacept treatment (provide for RETREATMENT requests)
Date of assessment _____	Date of assessment _____
1. Rheumatologist global assessment (0-10) _____ 2. Patient global assessment (0-10) _____ 3. No. of active joints* _____ 4. No. of joints with LROM _____ 5. CHAQ (0-3) _____ 6. ESR (mm/hr) _____ or CRP _____	1. Rheumatologist global assessment (0-10) _____ 2. Patient global assessment (0-10) _____ 3. No. of active joints* _____ 4. No. of joints with LROM _____ 5. CHAQ (0-3) _____ 6. ESR (mm/hr) _____ or CRP _____
<small>*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both</small>	<small>*joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both</small>

Please provide the following information for ALL NEW requests

Previous medications utilized: Dose, duration and response is required

DMARD(s) (please specify agents)

Adalimumab

Etanercept

Tocilizumab

Other (please specify agent)

Additional information relating to request (e.g. reasons why any of the above therapies were not tried)

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