

ABATACEPT for Polyarticular Juvenile Idiopathic Arthritis

SPECIAL AUTHORIZATION REQUEST FORM

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.

					~,		or many openior on an ag programm
PATIENT INFORMATION			COVERAGE TYPE				
PATIENT LAST NAME	FIRST NAME	INITIAL			Alberta Blue Cross Alberta Human Services		
DATE OF BIRTH: YYYY/MM/DD	ALBERTA PER	TH NUMBER			Other		
STREET ADDRESS	C	CITY	PR	OV F	POSTAL CODE	ID/CLIEN	T/COVERAGE NUMBER
PRESCRIBER INFORMATION			l.				
PRESCRIBER LAST NAME FIRS	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION						
			☐ CPSA	[☐ ACO	REGIS	TRATION NUMBER
STREET ADDRESS			☐ CARNA ☐ ADA+C				
			☐ ACP		Other		
			PHONE			FAX	
CITY, PROVINCE							
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED						
Please provide the following informat	ion for ALL	requests					
			weight (kg) Dosage				
☐ Polyarticular Juvenile Idiopathic Arthritis				As also a fine more and			
☐ Other (please specify)				Dos	ing frequenc	Э	
Please provide reason if a switch from a c	different biolo	gic agent	to abatacept	is requ	uested		
Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy							
		ACR Pedi 30 RESPONSE score at 16 to 20 weeks after first dose					
Current ACR Pedi 30 FLARE score (provi	de for ALL red	quests)	of previous requests)	abata	cept treatme	nt (provi	de for RETREATMENT
Data of account			Date of assessment				
Date of assessment			Date of asse	ssmen	ιτ		
Rheumatologist global 4. N	lo. of joints		1. Rheumat	ologist.	alobal	4	No. of joints
Rheumatologist global assessment (0-10) w	lo. of joints ith LROM		assessm	ent (0-	global 10)	4.	with LROM
2. Patient global 5. C assessment (0-10)	HAQ (0-3)		2. Patient global assessment (0-10)		5.	CHAQ (0-3)	
3. No. of active joints* 6. E	SR (mm/hr)		3. No. of active joints*		ıts*	6.	ESR (mm/hr)
0	r CRP						or CRP
*joints with swelling not due to deformity or joints with limitenderness or both	*joints with swelling not due to deformity or joints with limitation of motion with pain,						
Please provide the following information for ALL NEW requests							
Previous medications utilized: Dose, duration a		•					
DMARD(s) (please specify agents)		- 4					
Adalimumab							
☐ Etanercept							
☐ Tocilizumab							
☐ Other (please specify agent)							
Additional information relating to request (e.g. reasons why any of the above therapies were not tried)							
		1					
PRESCRIBER'S SIGNATURE D		and this request to					
Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta T5J 3C5						5	
							106 toll free all other areas
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.



