ALBERTA BLUE CROSS®

ADALIMUMAB/ ETANERCEPT/ TOCILIZUMAB 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.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ Alberta Blue Cross ☐ Alberta Human Services ☐ 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
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			**FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED**

Please provide the following information for ALL requests

Diagnosis

☐ Polyarticular Juvenile Idiopathic Arthritis

☐ Other (please specify)

Indicate requested drug[1]

☐ Abrilada ☐ Actemra ☐ Amgevita ☐ Brenzys ☐ Erelzi ☐ Hadlima ☐ Hulio ☐ Hyrimoz ☐ Idacio ☐ Simlandi ☐ Yuflyma

1. For Biosimilar Initiative Exception Requests, please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form

For Actemra, Brenzys, or Erelzi requests, indicate current weight (kg)

Dosage

Frequency

For patients new to coverage but currently maintained on the requested drug, provide the treatment start date (YYYY-MM-DD) _____

Please provide reason if a switch to a different biologic agent is requested

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

Pre-treatment ACR Pedi 30 score (provide for NEW requests for treatment naïve and treatment experienced patients)

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 _____

* joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both

Current ACR Pedi 30 score (provide for ALL RENEWAL requests and for INITIAL requests for treatment experienced patients)

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 _____

* joints with swelling not due to deformity or joints with limitation of motion with pain, tenderness or both

Please provide the following information for ALL NEW requests

Previous DMARDs utilized (specify agents): Dose, duration and response is required

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

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST