ALBERTA BLUE CROSS®

RITUXIMAB for Granulomatosis with Polyangiitis / Microscopic Polyangiitis 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				COVERAGE TYPE
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ 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 REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Indication for use

☐ Induction of remission of granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis)

☐ Induction of remission of microscopic polyangiitis (MPA)

☐ Other (please specify) _____

Indicate requested drug

☐ Riximyo ☐ Ruxience

☐ Truxima

Patient's body surface area (per square metre)

Requested dose

Dosing frequency

Please provide the following information for all NEW requests

Severity and organ(s) affected

a) Is the patient's disease life- or organ-threatening? ☐ Yes ☐ No

b) **If yes,** specify the organ(s) affected

_____

c) **If yes,** specify how the organ(s) is/are threatened

_____

Laboratory evidence of disease

Does the patient have a positive serum as say for either a) or b) below? (Note: copy of the lab report must be provided)

	YES	NO	Not tested
a) proteinase 3-ANCA….....	☐	☐	☐
b) myeloperoxidase-ANCA……..	☐	☐	☐

Previous cyclophosphamide usage: ONE of the following reasons must be specified

☐ The patient has failed a minimum of six intravenous pulses of cyclophosphamide

☐ The patient has failed three months of oral cyclophosphamide therapy

☐ The patient has a severe intolerance or an allergy to cyclophosphamide. Specify the nature of intolerance _____

☐ Cyclophosphamide is contraindicated. Specify the nature of contraindication _____

☐ The patient has received a cumulative lifetime dose of at least 25 grams of cyclophosphamide

Requests for treatment of RELAPSE following a rituximab-induced remission

Severity and organ(s) affected

a) Is the patient's disease life- or organ-threatening? ☐ Yes ☐ No

b) Is the patient experiencing worsening symptoms in two or more organs? ☐ Yes ☐ No

c) **If yes to a) or b),** specify the organ(s) affected _____

d) **If yes to a) or b),** specify how the organ(s) is/are threatened _____

Note: Additional coverage may be approved no sooner than six months after previous rituximab treatment.

Please provide the date of the last dose of the previous course of treatment with rituximab _____

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

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	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

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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