ALBERTA BLUE CROSS®

DABIGATRAN/ EDOXABAN 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	☐ 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			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Notes: Apixaban 2.5 mg and 5mg and Rivaroxaban 2.5 mg, 10 mg, 15 mg and 20 mg are regular benefits on the Alberta Drug Benefit List.

Drug requested (check ONE box)

☐ **Dabigatran (e.g. Pradaxa) → complete Section I only**

☐ **Edoxaban (e.g. Lixiana) → complete Section I and/or II**

Section I Prevention of stroke and systemic embolism in atrial fibrillation (AF) patients

a) Does the patient have non-valvular atrial fibrillation (AF)?

Yes No

b) Please indicate if **warfarin** was used

☐ Yes → If yes, please indicate if a **two month trial of warfarin** was used

☐ Yes ☐ No, please specify reason _____

☐ No → If no, please elaborate

a) If the patient has a contraindication to warfarin, provide information regarding the nature of the contraindication

_____

b) If this patient is unable to monitor via INR testing services, please specify the reason

_____

Section II EDOXABAN (e.g. Lixiana) for treatment of venous thromboembolic events

****Special authorization may be granted for up to six months****

a) Is the request for **treatment** of deep vein thrombosis (DVT)? ☐ No ☐ Yes → date of most recent event _____

b) Is the request for **treatment** of a pulmonary embolism (PE)? ☐ No ☐ Yes → date of most recent event _____

Additional information related to the request

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.