ALBERTA BLUE CROSS®

ARIPIPRAZOLE/PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION 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			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested

☐ **Aripiprazole Prolonged Release Injection (e.g. Abilify Maintena)**

☐ **Risperidone Prolonged Release Injection (e.g. Risperdal Consta)**

☐ **Paliperidone 1-Month Prolonged Release Injection (e.g. Invega Sustenna)**

☐ **Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Trinza)**

Diagnosis

☐ Schizophrenia or related psychotic disorder ☐ Other (please specify) _____

Compliance issues

Has this patient demonstrated a pattern of significant non-compliance with other dosage forms that is compromising or has compromised this patient's therapeutic success?

☐ Yes ☐ No, specify reason _____

Previous drug therapy

Is the patient refractory to a trial of at least one other antipsychotic therapy

☐ Yes ☐ No, specify reason _____

Risperidone or Paliperidone requests only

Previous risperidone or paliperidone therapy: Does the patient possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy?

☐ Yes ☐ No, specify reason _____

Aripiprazole requests only

Previous aripiprazole therapy: Does the patient possess clinical evidence of previous successful treatment with aripiprazole therapy?

☐ Yes ☐ No, specify reason _____

Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Trinza) requests only

Has this patient been maintained on Paliperidone 1-Month Prolonged Release Injection (e.g. Invega Sustenna) for at least four months?

☐ Yes ☐ No, specify reason _____

Additional information relating to request

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

ALBERTA BLUE CROSS®

ARIPIPRAZOLE/PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION
SPECIAL AUTHORIZATION CRITERIA

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

Criteria for Coverage

ARIPIPRAZOLE PROLONGED RELEASE INJECTION (e.g. Abilify Maintena)

"For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with aripiprazole therapy;

AND

Is refractory to a trial of at least one other antipsychotic therapy.

Special Authorization may be granted for six months."

This product is eligible for auto-renewal.

PALIPERIDONE 1-MONTH PROLONGED RELEASE INJECTION (e.g. Invega Sustenna)

“For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND

- Is refractory to a trial of at least one other antipsychotic therapy.

Special Authorization may be granted for six months.”

This product is eligible for auto-renewal.

PALIPERIDONE 3-MONTH PROLONGED RELEASE INJECTION (e.g. Invega Trinza)

“For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND

- Is refractory to a trial of at least one other antipsychotic therapy.

To be considered for coverage of Invega Trinza, patients must have been maintained on Invega Sustenna for at least four months. The last two doses of Invega Sustenna should be the same dosage strength and dosing interval, before initiating Invega Trinza.

Special Authorization may be granted for six months.”

This product is eligible for auto-renewal.

RISPERIDONE PROLONGED RELEASE INJECTION (e.g. Risperdal Consta)

“For the management of the manifestations of schizophrenia and related psychotic disorders in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success and who possess clinical evidence of previous successful treatment with risperidone or paliperidone therapy;

AND

- Is refractory to a trial of at least one other antipsychotic therapy.

Special Authorization may be granted for six months.”

This product is eligible for auto-renewal.