

# 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.

BRITH DATE (YYYYMM/DD)  ALBERTA PERSONAL HEALTH NUMBER  STREET ADDRESS  CITY  PROV  POSTAL CODE  PRESCRIBER LAST NAME  FIRST NAME  INITIAL  CARRA  CARRA  ADARC  TREGSTRATION NUMBER  FAX NUMBER MUST BE PROVIDED WITH EACH  REQUEST SUBMITTED  Indicate which drug is requested  Aripiprazole Protonged Release Injection (e.g., Risperda Consta)  Congliance Issues  Base the patient demonstrated a pattern of significant non-compliance with other dosage forms that is compromising or has compromised this patient shrapeute success?  Previous drug therapy  The patient demonstrated a pattern of significant non-compliance with other dosage forms that is compromising or has compromised this patient demonstrated a pattern of significant non-compliance with other dosage forms that is compromising or has compromised this patient for patient of previous successful treatment with application or Paliperidone or Paliperidone therapy?  Previous drug therapy  Risperda on Protonged Release Injection (e.g. invega Trinza)  Previous drug therapy  Risperda on Paliperidone requests only  Previous priparatione or paliperidone therapy?  Previous priparation or paliperidone or paliperidone or palip	PATIENT INFORMATION COVERAGE TYPE							
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POSTAL CODE  FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED  Indicate which drug is requested   Aripiprazole Prolonged Release Injection (e.g. Risperidone Prolonged Release Injection (e.g. Abilify Maintena)   Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Sustenna)   Paliperidone 3-Month Prolonged Release Injection (e.g. Invega Sustenna)    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 Is the patient refractory to a trial of at least one other antipsychotic therapy Is the patient refractory to a trial of at least one other antipsychotic therapy Is patient or Paliperidone requests only  Previous drug therapy Is the patient refractory to a trial of at least one other antipsychotic therapy Is patient or Paliperidone 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  Prescribers Signature  DATE   Please forward this request to Alberta Blue Cross, Clinical Drug Services 100009 108 Street NW, Edmonton, Alberta T5J 305 FAX: 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas	STREET ADDRESS							
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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.







# 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.



