ALBERTA BLUE CROSS®

ABATACEPT/ ADALIMUMAB/ ANAKINRA/ BARICITINIB/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ SARILUMAB/ TOCILIZUMAB/ TOFACITINIB/ UPADACITINIB for Rheumatoid 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

BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other

REGISTRATION NUMBER

PHONE

FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

- ☐ Rheumatoid Arthritis
- ☐ Other (specify)

Indicate requested drug[1]

☐ Abrilada	☐ Brenzys	☐ Hulio	☐ Kevzara	☐ Renflexis	☐ Xeljanz
☐ Actemra	☐ Cimzia	☐ Hyrimoz	☐ Kineret	☐ Rinvoq	☐ Xeljanz XR
☐ Amgevita	☐ Erelzi	☐ Idacio	☐ Olumiant	☐ Simlandi	☐ Yuflyma
☐ Avsola	☐ Hadlima	☐ Inflectra	☐ Orencia	☐ Simponi	

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

Current weight (kg)

Dosage and frequency

Date of last dose

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

*Pre-treatment scores	Current scores
DAS28 Score ___.____ Date _____	DAS28 Score ___.____ **OR** ☐ ACR20 (renewals only) Date _____
HAQ Score ___.___ ___ Date _____	HAQ Score ___.___ ___ Date _____

*Requests for patients new to the requested drug and requests for patients new to coverage but currently maintained on the requested drug require pre-treatment scores. All scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places.

Please provide reason if a switch to a different drug is requested

For all drugs EXCEPT Abatacept
Will the patient be maintained on methotrexate in combination with the requested drug?
☐ YES ☐ NO

For Abatacept ONLY
Will the patient be maintained on methotrexate or another DMARD in combination with Abatacept? ☐ YES ☐ NO

If NO to any of the above, please specify reason

Please provide the following information for all NEW requests

Previous medications utilized: Dose, duration and response are required for ALL FOUR of the following or contraindications, if applicable

- ☐ Methotrexate PO _____
- ☐ Methotrexate SC or IM _____
- ☐ Methotrexate with another DMARD other than leflunomide (specify agent) _____
- ☐ Leflunomide _____

For Kineret requests, please indicate if the following drugs were tried and the response to therapy, or contraindications, if applicable

☐ Abatacept _____	☐ Etanercept _____	☐ Rituximab _____
☐ Adalimumab _____	☐ Golimumab _____	☐ Sarilumab _____
☐ Certolizumab _____	☐ Infliximab _____	☐ Tocilizumab _____

Additional information relating to 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