ALBERTA BLUE CROSS®

ADALIMUMAB/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ SECUKINUMAB for Ankylosing Spondylitis

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
STREET ADDRESS	☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
CITY, PROVINCE	PHONE / FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	Indicate requested drug[1]				Current weight (kg)	Dosage and frequency
☐ Ankylosing Spondylitis (meeting modified NY criteria)	☐ Abrilada	☐ Cimzia	☐ Hulio	☐ Renflexis		
	☐ Amgevita	☐ Cosentyx	☐ Hyrimoz	☐ Simlandi		
☐ Other (specify)	☐ Avsola	☐ Erelzi	☐ Idacio	☐ Simponi		
	☐ Brenzys	☐ Hadlima	☐ Inflectra	☐ Yuflyma		**Date of last dose**

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

Please provide the following information for all NEW requests

Previous medications utilized

Have two or more NSAIDs been tried for a minimum of four weeks each at maximum tolerated or recommended doses?

☐ YES (please **SPECIFY** below) ☐ NO

	Please **SPECIFY** the NSAID	Please **SPECIFY** the dose, duration, and response
NSAID #1		
NSAID #2		

Other, please **SPECIFY** ____________________

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

NEW requests: Please provide *pre-treatment scores

BASDAI #1	Date (YYYY-MM-DD)
BASDAI #2	Date (YYYY-MM-DD)
Spinal Pain VAS #1 (cm)	Date (YYYY-MM-DD)
Spinal Pain VAS #2 (cm)	Date (YYYY-MM-DD)

* Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores. Scores 1 and 2 for each parameter must be at least eight weeks apart.

RENEWAL requests: Please provide current scores

BASDAI	Date (YYYY-MM-DD)
Spinal pain VAS (cm)	Date (YYYY-MM-DD)

Please provide reason if a switch to a different biologic agent is requested

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

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

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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