ADALIMUMAB/ BIMEKIZUMAB/ ETANERCEPT/ GUSELKUMAB/ INFLIXIMAB/ IXEKIZUMAB/ RISANKIZUMAB/ SECUKINUMAB/ TILDRAKIZUMAB/ USTEKINUMAB for Plaque Psoriasis

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

Please provide the following information for ALL requests

Diagnosis
☐ Plaque Psoriasis
☐ Other (specify)

Indicate requested drug

Tier 1 Drugs[1,2]

☐ Abrilada ☐ Brenzys ☐ Hulio ☐ Inflectra ☐ Taltz
☐ Amgevita ☐ Cosentyx ☐ Hyrimoz ☐ Renflexis ☐ Tremfya
☐ Avsola ☐ Erelzi ☐ Idacio ☐ Simlandi ☐ Yuflyma
☐ Bimzelx ☐ Hadlima ☐ Ilumya ☐ Skyrizi

Tier 2 Drugs[1]

☐ Stelara

1. See p. 2 for SA Criteria Change; 2. 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) ________________________

Location: Prior to treatment with the requested biologic, did the patient have significant involvement of the face, palms of the hands, soles of the feet or genital region?
☐ YES ☐ NO

***Pre-treatment scores**		**Current scores**	
PASI ____________	Date ____________	PASI ____________	Date ____________
DLQI ____________	Date ____________	DLQI ____________	Date ____________

*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.
Note: PASI and DLQI scores are required for all requests including those requests for patients that have significant involvement of the face, palms, soles of the feet or genital region.

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

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

Please provide the following information for all NEW requests

Previous medications/therapies utilized - Check all that apply and indicate dose, duration and response, or contraindication, if applicable

☐ Methotrexate PO ____________________
☐ Methotrexate SC or IM ____________________
☐ Cyclosporine ____________________
☐ Phototherapy ____________________

For TIER 2 drug requests
Please indicate which TIER 1 drugs were tried and the response to therapy, reasons for discontinuation or contraindications, if applicable

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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ALBERTA BLUE CROSS®

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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

1. Special Authorization Criteria Change

As of December 12, 2019, tiering will be implemented for biologic drugs for plaque psoriasis. Patients must trial the number of drugs in tier 1 that is equal to the number of different mechanisms of action of the tier 1 drug products prior to accessing a tier 2 drug. Should therapy with a tier 1 therapeutic option(s) fail or be inappropriate due to intolerance or contraindication, access to a more expensive tier 2 agent *may* be considered.

Health Area / Indication	Drugs in Tier 1	Drugs in Tier 2
Dermatology (Plaque Psoriasis)	• Abrilada (adalimumab) • Amgevita (adalimumab) • Avsola (infliximab) • Bimzelx (bimekizumab) • Brenzys (etanercept) • Cosentyx (secukinumab) • Erelzi (etanercept) • Hadlima (adalimumab) • Hulio (adalimumab) • Hyrimoz (adalimumab) • Idacio (adalimumab) • Ilumya (tildrakizumab) • Inflectra (infliximab) • Renflexis (infliximab) • Simlandi (adalimumab) • Skyrizi (risankizumab) • Taltz (ixekizumab) • Tremfya (guselkumab) • Yuflyma (adalimumab) *Number of tier 1 drugs that must be trialed: 3*	• Stelara (ustekinumab)

For Tiering Exception Requests

For exception requests for tier 2 drugs for patients already on the requested tier 2 drug

Please provide the date that the tier 2 drug was initiated (YYYY-MM-DD) ______________________

Please indicate whether the patient is stabilized on the tier 2 drug ☐ YES ☐ NO

Please provide information on the previous method of reimbursement for the tier 2 drug (such as private coverage, compassionate supply)

____

For exception requests for tier 2 drugs for patients new to the requested tier 2 drug

Please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form.

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