ALBERTA BLUE CROSS®

ADALIMUMAB/ RISANKIZUMAB/ VEDOLIZUMAB for Crohn's/ INFLIXIMAB for Crohn's/ Fistulizing Crohn's Disease
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 OR 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

- ☐ Moderately to Severely Active Crohn's (MSAC)
- ☐ Fistulizing Crohn's
- ☐ Other (please specify) _____

Indicate requested drug[1]

- ☐ Abrilada ☐ Entyvio ☐ Hyrimoz ☐ Renflexis ☐ Yuflyma
- ☐ Amgevita ☐ Hadlima ☐ Idacio ☐ Simlandi
- ☐ Avsola ☐ Hulio ☐ Inflectra ☐ Skyrizi

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 INITIAL requests, please indicate if the drug is requested for a

- ☐ NEW patient who has never been treated with the requested drug by any health care provider.
- ☐ EXISTING patient who is being treated or has previously been treated with the requested drug.
  Please provide the treatment start date _____

Please provide reason if a switch to a different biologic agent or change in dose is requested.

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

Infliximab for Fistulizing Crohn's Disease

INITIAL requests

Dose, duration and response are required for all medications previously utilized.

Azathioprine

6-mercaptopurine

Antibiotic(s) (specify drug name)

NEW patient

Does the patient have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite previous therapy?

☐ Yes ☐ No

EXISTING patient

Please indicate response to treatment with Infliximab

- ☐ Closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline
- ☐ Incomplete response (please specify)

_____

- ☐ Loss of response to 5mg/kg dosing: increase to 10mg/kg required

Adalimumab, Infliximab, Risankizumab or Vedolizumab for MSAC

INITIAL requests

Dose, duration and response are required for all medications previously utilized, or contraindications, if applicable

Azathioprine

6-mercaptopurine

Methotrexate

Mesalamine

Glucocorticoid(s) (specify drug name)

ALL requests

Modified Harvey-Bradshaw Index score _____ Date of score _____

For Infliximab requests for an increase to 10mg/kg dosing

1) Is the patient already maintained on Infliximab 10 mg/kg?

☐ Yes ☐ No

2) Confirm the patient had an incomplete response to Infliximab 5mg/kg dosing

☐ Yes ☐ No (explain) _____

3) Most recent Modified Harvey-Bradshaw Index score from when the patient was *responding* to 5mg/kg dosing _____ Date_____

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