

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NO. <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage

"For the treatment of osteoporosis in patients with a 20% or greater 10-year fracture risk who have documented intolerance to alendronate 70 mg or risedronate 35 mg. Special authorization may be granted for 6 months."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 6 months after the last dose of denosumab 60 mg/syr injection syringe."

"Requests for other osteoporosis medications covered via special authorization will not be considered until 12 months after the last dose of zoledronic acid 0.05 mg/ml injection."

Note: The fracture risk can be determined by the World Health Organization's fracture risk assessment tool, FRAX, or the most recent (2010) version of the Canadian Association of Radiologist and Osteoporosis Canada (CAROC) table.

*** Alendronate 70 mg and risedronate 35 mg are regular benefits not requiring Special Authorization.**

** Alendronate and risedronate also have special authorization criteria for Paget's disease. Please refer to the Alberta Drug Benefit List for alendronate and risedronate's other criteria for the indication of Paget's disease.

Please provide the following information for ALL requests:

Indicate which drug is requested (check ONE box): Alendronate Raloxifene Risedronate

Please provide the following information for all NEW requests:

Diagnosis: For the treatment of Osteoporosis Osteopenia Other, please specify: _____

Fracture risk:

a) Has the patient experienced FRACTURES related to the diagnosis? No Yes

b) Does the patient have a 20% or greater 10-year fracture risk? No Yes

Information regarding previous alendronate 70mg or risedronate 35mg use:

alendronate 70mg or risedronate 35mg HAS been utilized.
 Nature of response: Intolerance
 Other (please specify): _____

alendronate 70mg or risedronate 35mg has NOT been utilized (specify reason(s)): _____

PRESCRIBER'S SIGNATURE	DATE	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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

