ALBERTA BLUE CROSS®

RITUXIMAB 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				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 ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
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
☐ Rheumatoid Arthritis
☐ Other (specify)

Indicate drug requested
☐ Riximyo ☐ Ruxience ☐ Truxima

Dosage and frequency

Pre-treatment scores*
DAS28 Score _____
Date _____

AND
HAQ Score _____
Date _____

Requests for re-treatment after two-dose course
Date of initial dose of the previous course of therapy
_____

Response scores 16 to 24 weeks after initial dose of previous course of therapy
DAS28 Score _____ Date _____
HAQ Score _____ Date _____

Current scores
DAS28 Score _____ Date _____
HAQ Score _____ Date _____

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

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

* New requests for patients currently maintained on the requested biologic also require pre-treatment scores. 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.

Will the patient be maintained on methotrexate in combination with rituximab?
☐ YES ☐ NO (If not, please specify reason)

Please provide the following information for all NEW requests

Previous medications/therapies utilized: Dose, duration and response is required for ALL FIVE of the following, or contraindications, if applicable

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