ALBERTA BLUE CROSS®

ADALIMUMAB
for Hidradenitis Suppurativa
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
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other: _____
BIRTHDATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
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
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

☐ Active moderate to severe Hidradenitis Suppurativa

☐ Other (specify) _____

Indicate Requested Drug[1]

☐ Abrilada ☐ Hadlima ☐ Hyrimoz ☐ Simlandi

☐ Amgevita ☐ Hulio ☐ Idacio ☐ Yuflyma

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

Please provide the following information for INITIAL requests

1) Total abscess and nodule (AN) count at pre-treatment baseline _____ and date of count _____

2) Does the patient have lesions in at least two distinct anatomical areas? ☐ Yes ☐ No

3) Does the patient have Hurley Stage II or III lesions in at least one anatomical area? ☐ Yes ☐ No

4) Previous therapy

a) Have systemic antibiotics been tried for at least 90 days?

☐ Yes → Specify antibiotics and response _____

☐ No → Specify reason _____

b) Is there documented non-response to conventional therapy other than systemic antibiotics?

☐ Yes → Specify which therapies have been tried, including dose and duration

_____

☐ No → Specify reason _____

Please provide the following information for RENEWAL requests

1) Current AN count _____ and date of count _____

2) Indicate the patient's response to treatment (check ALL that apply)

☐ 50 per cent or greater reduction in AN count from pre-treatment baseline

☐ No increase in abscess count or draining fistula count relative to pre-treatment baseline

Note: Treatment with adalimumab should be discontinued if there is insufficient improvement after 12 weeks of treatment.

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.