

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	
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	
STREET ADDRESS			PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
CITY, PROVINCE			PHONE		FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

Diagnosis	Dosage & frequency	Please indicate if this patient is
<input type="checkbox"/> Giant cell arteritis (GCA) <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Starting first treatment course upon approvalcomplete section I <input type="checkbox"/> Renewal request at 12 to 16 weeks of therapy.....complete section II <input type="checkbox"/> New to coverage but currently maintained on drug.....complete sections I and II <input type="checkbox"/> Re-treatment requestscomplete sections I and III

Section I: Please complete for all NEW requests for first or subsequent treatment courses (Initial approval for 16 weeks)

1) The current tocilizumab treatment course will be (or was) initiated in combination with a glucocorticoid?
 Yes → specify glucocorticoid _____
 No → indicate reason(s) _____

2) If the patient is currently on tocilizumab, indicate start date of treatment course (YYYY-MM-DD) _____

3) For coverage, tocilizumab must be initiated in consultation with a specialist in internal medicine, rheumatology or neurology. Please indicate the name of the specialist consulted for the current treatment course, where applicable _____

Section II: Please complete for RENEWAL requests at 12 to 16 weeks of therapy (Renewal approval for 36 weeks)

4) Has the patient's disease flared* while on tocilizumab? Yes No
 *Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

5) Has the patient's C-reactive protein (CRP) normalized to <1 mg/dL (<10 mg/L)?
 Yes → indicate CRP level _____ mg/dL (or _____ mg/L) and date (YYYY-MM-DD) _____
 No → explain _____

Section III: Please complete for RE-TREATMENT requests

6) Provide the date of discontinuation of the previous tocilizumab treatment course (YYYY-MM-DD) _____

7) Has the patient's disease flared* after discontinuation of treatment with tocilizumab?
 Yes
 No → explain _____
 *Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

