

ABROCITINIB/DUPILUMAB/UPADACITINIB For Atopic Dermatitis 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		<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				
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER	
PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
ADDRESS			REGISTRATION NUMBER		
			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other		
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
Please provide the following information for ALL requests					
Requested drug <input type="checkbox"/> Abrocitinib (e.g. Cibinqo) <input type="checkbox"/> Dupilumab (e.g. Dupixent) <input type="checkbox"/> Upadacitinib (e.g. Rinvoq)					
Diagnosis <input type="checkbox"/> Moderate to severe atopic dermatitis <input type="checkbox"/> Other (please specify) _____			Dosage and frequency		Current weight (kg)
Combination therapy Will the requested drug be used in combination with phototherapy or immunomodulating drugs				<input type="checkbox"/> Yes	<input type="checkbox"/> No
For patients new to coverage but currently maintained on the requested drug, provide the treatment start date _____					
Please provide the following pre-treatment information for NEW requests for treatment-naïve and treatment-experienced patients					
1) Pre-treatment Investigator's Global Assessment (IGA) score _____ and date _____					
2) Pre-treatment Eczema Area and Severity Index (EASI) score _____ and date _____					
3) Previous medications and therapies utilized —check all that apply and indicate dose, duration and response to each, or indicate contraindication, if applicable <input type="checkbox"/> Topical corticosteroid _____ <input type="checkbox"/> Topical calcineurin inhibitor _____ <input type="checkbox"/> Conventional systemic immunomodulatory drug (must be steroid sparing). Specify name: _____ <input type="checkbox"/> Phototherapy _____					
Please provide the following information for RENEWAL requests and INITIAL requests for treatment experienced patients					
1) Current EASI score _____ and date _____					
2) For upadacitinib requests to increase the dose to 30 mg , please indicate if the patient had an inadequate response to initial coverage with 15 mg - for patients 18 to 64 years of age only				<input type="checkbox"/> Yes	<input type="checkbox"/> No
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.

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

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