ALBERTA BLUE CROSS®

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	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ 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 ☐ 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

Requested drug ☐ Abrocitinib (e.g. Cibinqo) ☐ Dupilumab (e.g. Dupixent) ☐ Upadacitinib (e.g. Rinvoq)

Diagnosis	**Dosage and frequency**	**Current weight (kg)**
☐ Moderate to severe atopic dermatitis ☐ Other (please specify) _____		

Combination therapy		
Will the requested drug be used in combination with phototherapy or immunomodulating drugs	☐ Yes	☐ No

For patients new to coverage but currently maintained on the requested drug, provide the treatment start date _____

Please provide the following <u>pre-treatment</u> 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

☐ Topical corticosteroid _____

☐ Topical calcineurin inhibitor _____

☐ Conventional systemic immunomodulatory drug (must be steroid sparing). Specify name: _____

☐ 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	☐ Yes	☐ 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.