ALBERTA BLUE CROSS®

ANIFROLUMAB
For Systemic Lupus Erythematosus
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

Diagnosis
☐ Moderate to severe systemic lupus erythematosus
☐ Other, specify
_____

Please indicate if this patient is
☐ starting drug upon approval ……..complete section I
☐ new to coverage but currently maintained on drug… complete section I & II
☐ submitting renewal request ……..complete section II

Does the patient have severe or unstable neuropsychiatric SLE or active severe SLE nephritis. ☐ **Yes** ☐ **No**

Section I: INITIAL requests for treatment naïve and treatment experienced patients

1) Is the patient inadequately controlled with oral corticosteroids (OCS) dose of at least 10 mg/day of prednisone or its equivalent in addition to standard therapy? ☐ Yes ☐ No

2) **Pre-treatment** Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score _____ Date_____

3) If a British Isles Lupus Activity Group (BILAG-2004) will be used for renewal assessment, please provide **pre-treatment** BILAG-2004 scores and Date _____

Constitutional	_____	Musculoskeletal	_____	Ophthalmic	_____
Mucocutaneous	_____	Cardiorespiratory	_____	Renal	_____
Neuropsychiatric	_____	Gastrointestinal	_____	Hematological	_____

Section II: RENEWAL requests and INITIAL requests for treatment-experienced patients

1) OCS dose has decreased to </= 7.5 mg/day of prednisone or its equivalent ☐ Yes ☐ No

2) **Current** Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score _____ Date_____ **OR**

3) **Current** British Isles Lupus Activity Group (BILAG-2004) scores and Date _____

Constitutional	_____	Musculoskeletal	_____	Ophthalmic	_____
Mucocutaneous	_____	Cardiorespiratory	_____	Renal	_____
Neuropsychiatric	_____	Gastrointestinal	_____	Hematological	_____

Additional information related 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.