ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

SATRALIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

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	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
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	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS			PHONE	FAX
CITY, PROVINCE				
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

Diagnosis

☐ Neuromyelitis optica spectrum disorder (NMOSD)

☐ 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

Dosage and frequency requested

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

1)	Is the patient anti-aquaporin-4 (AQP4) antibody positive?	☐ Yes	☐ No
2)	Patient had at least one relapse of NMOSD in the previous 12 months prior to satralizumab initiation?	☐ Yes	☐ No

3) Was the patient refractory to or intolerant of an adequate trial of rituximab for NMOSD?

☐ Yes

☐ No, provide reason(s) why rituximab cannot be tried

_____

4) If rituximab was not tried, was another preventative treatment(s) used, such as other monoclonal antibody, azathioprine, mycophenolate or other immunosuppressant?

☐ Yes, specify medication(s) used _____

☐ No, provide reason(s) why other preventative treatments cannot be tried

_____

5) **Pre-treatment** Expanded Disability Status Scale (EDSS) score _____ Date _____

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

Current EDSS _____ Date _____

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