ALBERTA BLUE CROSS®

ALMOTRIPTAN / NARATRIPTAN / RIZATRIPTAN / SUMATRIPTAN / ZOLMITRIPTAN 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

Criteria for Coverage – Alberta Health

Special Authorization

For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed.
For the treatment of acute migraine attacks in patients 65 years of age and older who have been using [the requested triptan product] prior to turning 65.

Restricted Benefit

Almotriptan products: This product is a benefit for patients 12 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed.
Naratriptan, rizatriptan, sumatriptan and zolmitriptan products: This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where standard therapy has failed.

Criteria for Coverage – Alberta Human Services

Special Authorization

For the treatment of acute migraine attacks in patients where other standard therapy has failed.

Please provide the following information for all requests

Drug Requested

☐ Almotriptan ☐ Naratriptan ☐ Rizatriptan ☐ Sumatriptan ☐ Zolmitriptan

Diagnosis

☐ Migraine headaches ☐ Other, specify _____

Previous therapy

Please indicate if other standard therapy for treatment of acute migraine attacks was tried

☐ Yes → specify name of medication and response _____

☐ No → specify reason _____

For patients 65 years of age and older, has the patient been using a triptan product prior to turning 65? ☐ 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.

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.