ALBERTA BLUE CROSS®

ADALIMUMAB/ETANERCEPT/GOLIMUMAB/INFLIXIMAB for Psoriatic Arthritis

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:**
PATIENT LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NO.
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:

☐ Polyarticular Psoriatic Arthritis

☐ Pauciarticular Psoriatic Arthritis→Joints affected:

☐ Knee joint(s) ☐ Hip joint(s) ☐ Other (specify):

☐ Other (specify):

Current weight (kg):

Indicate requested drug:

☐ Adalimumab
☐ Etanercept
☐ Golimumab
☐ Infliximab

Dosage:

Dosing Frequency:

Scores:* DAS28 Score ___._____ **OR** ☐ ACR20 (renewals only) Date:_____

AND

HAQ Score ___.___ ___ Date: _____

* New requests for patients currently maintained on the requested biologic require pre-treatment scores. Scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places.

Please provide reason if a switch to a different biologic agent is requested:

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Will the patient be maintained on methotrexate in combination with the requested biologic?

☐ YES ☐ NO (If not, please specify reason):

Please provide the following information for all NEW requests:

Previous medications utilized: Dose, duration and response is required for ALL THREE of the following:

☐ Methotrexate PO:

☐ Methotrexate SC or IM:

☐ DMARD other than MTX (specify agent):

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

PRESCRIBER'S SIGNATURE	DATE	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.