

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	d
by Alberta Government sponsored drug programs	s.

PATIENT INFORMATION			COVERAGE TYPE:				
PATIENT LAST NAME	FIRST NAME		INITIAL	Alberta Blue Cross			
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEA	LTH NUMBER		Other			
STREET ADDRESS	CITY		POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:			
PRESCRIBER INFORMATION							
PRESCRIBER LAST NAME FIRST NAME INITIAL PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION							
			CPSA ACO REGISTRATION NO.				
			CARNA 🔲 ADA+C ACP 🔲 Other				
	PHONE:		FAX:				
CITY, PROVINCE							
POSTAL CODE	FAX N	FAX NUMBER MUST BE PROVIDED WITH EACH					
REQUEST SUBMITTED							
Please provide the following information for	or ALL requests:						
Diagnosis:		Current weight	Indicate red	quested	Dosage:		
Polyarticular Psoriatic Arthritis		(kg):	drug:				
Pauciarticular Psoriatic Arthritis -> Joints af				Dosing Frequency:			
☐ Knee joint(s) ☐ Hip joint(s) ☐ Oth		Etanero	•				
Other (specify):							
					n if a switch to a different		
Scores:* DAS28 Score OR ACR20 (renewals only) Date:				Please provide reason if a switch to a different biologic agent is requested:			
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.				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 Pleas	se forward this reques					
	•	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 SU							
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,							
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