ALBERTA BLUE CROSS®

ADALIMUMAB/ETANERCEPT/GOLIMUMAB/INFLIXIMAB for Ankylosing Spondylitis
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 REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
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:

☐ Ankylosing Spondylitis (meeting modified NY criteria)

☐ Other (please **SPECIFY**): _____

Current weight (kg):

Indicate requested drug:

☐ Adalimumab
☐ Etanercept
☐ Golimumab
☐ Infliximab

Dosage:

Dosing frequency:

Please provide the following information for all NEW requests:

Previous medications utilized:

Have two or more NSAIDs been tried for a minimum of 4 weeks each at maximum tolerated or recommended doses?

☐ YES (please **SPECIFY** below) ☐ NO

	Please **SPECIFY** the NSAID	Please **SPECIFY** the dose, duration, and response
NSAID #1:		
NSAID #2:		

Other, please **SPECIFY**:

Please provide the following information for all NEW* requests:

BASDAI #1	Date:
BASDAI #2:	Date:
Spinal Pain VAS #1 (cm):	Date:
Spinal Pain VAS #2 (cm):	Date:

* New requests for patients currently maintained on the requested biologic require pre-treatment scores. Scores 1 and 2 for each parameter must be at least 8 weeks apart.

Please provide the following information for all RENEWAL requests:

BASDAI	Date:
Spinal pain VAS (cm)	Date:

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.

Additional information relating to request:

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.

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.