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ALBERTA BLUE CROSS®

ADALIMUMAB for Crohn's / INFLIXIMAB for Crohn's / Fistulizing Crohn's Disease
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	ID/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:
- ☐ Moderately to Severely Active Crohn's
- ☐ Fistulizing Crohn's
- ☐ Other (specify) _____

Indicate requested drug:
- ☐ Adalimumab Dose:_____ Frequency:_____ Date of last dose:_____
- ☐ Infliximab Dose:_____ Frequency:_____ Date of last dose:_____

Current weight (kg):_____

For INITIAL request, please indicate if the drug is requested for
- ☐ NEW patient who has never been treated with the requested drug by any health care provider
- ☐ EXISTING patient who is being treated, or have previously been treated with the requested drug

Please provide reason if a switch to a different biologic agent or change in dose is requested:

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

Infliximab For Fistulizing Crohn's Disease:

INITIAL request:

Dose, duration and response is required for all medications previously utilized:

Azathioprine:

6-mercaptopurine:

Antibiotics (specify the drug name):

NEW patient:

Does the patient have actively draining perianal or enterocutaneous fistula(s) that have recurred or persisted despite previous therapy:

☐ Yes ☐ No

EXISTING patient:

Please indicate response to treatment with infliximab:

- ☐ Closure of individual fistulas as evidenced by no or minimal fistula drainage despite gentle finger compression of fistulas that were draining at baseline.
- ☐ Incomplete response (specify):

Adalimumab or Infliximab For Moderately to Severely Active Crohn's Disease:

INITIAL request:

Dose, duration and response is required for all medications previously utilized:

Azathioprine:

6-mercaptopurine:

Methotrexate:

Mesalamine:

Glucocorticoid(s) (specify drug name):

For ALL requests for Moderately to Severely Active Crohn's Disease, please provide

Modified Harvey-Bradshaw Index score: _____

Date of score: _____

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.