ALBERTA BLUE CROSS®

RITUXIMAB for Rheumatoid 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 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:
☐ Rheumatoid Arthritis
☐ Other (specify)

Dosage:

Dosing Frequency:

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

Scores:*

DAS28 Score _____

Date: _____

AND

HAQ Score _____

Date: _____

Requests for Re-treatment after 2 dose course

Date of initial dose of the previous course of therapy:

_____

Response Scores 16-24 weeks after initial dose of previous course of therapy:

DAS28 Score ___._ Date: _____

AND HAQ Score _____ Date: _____

Current scores:

DAS28 Score _____ Date: _____

AND HAQ Score _____ Date: _____

Date of last dose:

_____

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

* New requests for patients currently maintained on the requested biologic also 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.

Will the patient be maintained on methotrexate in combination with rituximab?

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

Please provide the following information for all NEW requests:

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

☐ Methotrexate PO:

☐ Methotrexate SC or IM:

☐ Methotrexate with another DMARD other than leflunomide (specify agent)

☐ Leflunomide:

☐ Anti-TNF therapy:

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.