ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

IMIQUIMOD
SPECIAL AUTHORIZATION REQUEST FORM

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	

Criteria for Coverage of IMIQUIMOD

For the treatment of Actinic Keratosis located on the head and neck in patients who have failed treatment with cryotherapy (where appropriate) and 5-fluorouracil (5-FU). Special authorization may be granted for 6 months.
This product is eligible for auto-renewal.

☐ **NEW Please provide the following information for NEW requests (check ALL that apply):**

Diagnosis:

☐ Actinic Keratosis → Area affected:

☐ Head or neck ☐ Other (specify): _____

☐ Other (specify):

Previous medications/therapies utilized:

Please indicate if the following medication/therapy have been tried and the response:

1) cryotherapy: ☐ Yes → Response:

☐ Lack of response ☐ Intolerance ☐ Other (specify):_____

☐ No → ☐ Not appropriate ☐ Other (specify):_____

AND

2) 5-fluorouracil (5-FU): ☐ Yes→ Response:

☐ Lack of response ☐ Intolerance ☐ Other (specify):_____

☐ No (specify reason, if applicable): _____

Additional information relating to request

☐ **RENEWAL**

This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).

Please indicate response to therapy:

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.