ALBERTA BLUE CROSS®

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

PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION
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

Indicate which drug is requested: ☐ **Risperidone Prolonged Release Injection** ☐ **Paliperidone Prolonged Release Injection**

☐ **NEW Please provide the following information for NEW requests:**

Diagnosis: ☐ schizophrenia or related psychotic disorder ☐ other, please specify

Compliance Issues: Has this patient demonstrated a pattern of significant non-compliance with other dosage forms that is compromising or has compromised this patient's therapeutic success?

☐ Yes ☐ No If no, please elaborate:

Previous drug therapy (CHECK ALL THAT APPLY): In order to comply with criteria, check at least two of the following:

☐ Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product

☐ Is refractory to trials of at least two other antipsychotic therapies (Note: one trial must include a first generation antipsychotic agent)

☐ Possesses clinical evidence of previous successful treatment with risperidone or paliperidone therapy

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.

ALBERTA BLUE CROSS®

PALIPERIDONE/RISPERIDONE PROLONGED RELEASE INJECTION

SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for Coverage of PALIPERIDONE PROLONGED RELEASE INJECTION

For the management of the manifestations of schizophrenia in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success AND who meet at least two of three of the following criteria:
-Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
-Is refractory to trials of at least two other antipsychotic therapies (Note: one trial must include a first generation antipsychotic agent); OR
-Possesses clinical evidence of previous successful treatment with risperidone or paliperidone therapy.

Special Authorization may be granted for six months. This product is eligible for auto-renewal.

Criteria for Coverage of RISPERIDONE PROLONGED RELEASE INJECTION

For the management of the manifestations of schizophrenia and related psychotic disorders in patients who demonstrate a pattern of significant non-compliance that compromises therapeutic success AND who meet at least two of three of the following criteria:
-Experiences extra-pyramidal symptoms with either an oral or depot first generation antipsychotic agent that precludes the use of a first generation antipsychotic depot product; OR
-Is refractory to trials of at least two other antipsychotic therapies (Note: one trial must include a first generation antipsychotic agent); OR
-Possesses clinical evidence of previous successful treatment with risperidone or paliperidone therapy.

Special Authorization may be granted for six months. This product is eligible for auto-renewal.