



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.

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

PATIENT INFORMATION table with fields: PATIENT LAST NAME, FIRST NAME, INITIAL, DATE OF BIRTH, ALBERTA PERSONAL HEALTH NUMBER, STREET ADDRESS, CITY, PROV, POSTAL CODE, COVERAGE TYPE (Alberta Blue Cross, Alberta Human Services, Other), IDENTIFICATION/CLIENT/COVERAGE No.

PRESCRIBER INFORMATION table with fields: PRESCRIBER LAST NAME, FIRST NAME, INITIAL, STREET ADDRESS, CITY, PROVINCE, POSTAL CODE, PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION (CPSA, ACO, CARNA, ADA+C, ACP, Other), REGISTRATION NO., PHONE, FAX, and a note: 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.

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.

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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.