

TOCILIZUMAB for Systemic Juvenile Idiopathic 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 N | AME | | INITIAL | Alberta Blue Cross Alberta Human Services Other |
| DATE OF BIRTH: Year / Month / Day | ALBERTA PERSONAL HEALTH NUMB | | | R | |
| STREET ADDRESS | | CITY | PROV | POSTAL CODE | IDENTIFICATION/CLIENT/COVERAGE NO: |
| PRESCRIBER INFORMATION | | | | | |
| PRESCRIBER LAST NAME FIRST NAME INITIAL | | | PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION | | |
| STREET ADDRESS | | | □ CPSA □ CARNA □ ACP | ☐ ACO ☐ ADA+C ☐ Other | REGISTRATION NO. |
| | | | PHONE: | | FAX: |
| CITY , PROVINCE | | | | | |
| POSTAL CODE | | | FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED | | |
| Please provide the following information for ALL requests: | | | | | |
| Diagnosis: Systemic Juvenile Idiopathic Arthritis Other (specify): | | | Patient's current weight (kg): | | : Requested dose (mg/kg): Dosing frequency: |
| | | | | | |
| Please provide the following information for NEW requests: | | | | | |
| Please check all of the following that apply: Fever (>38°C) for at least two weeks Lymphadenopathy | | | | | |
| Rash of systemic JIA Hepato | | | omegaly | | |
| Serositis Spleno | | | megaly | | |
| Previous medications utilized (specify agents): Dose, duration and response is required: | | | | | |
| NSAIDs: | | | | | |
| Systemic corticosteroids: | | | | | |
| Please provide the following information for RENEWAL requests: | | | | | |
| The patient is a responder as demonstrated by: (check all that apply) JIA ACR30 Absence of fever Reduction in inflammatory markers (e.g. CRP concentration of less than 15 mg/L or reduction in ESR) Other (specify): | | | | | |
| Additional information relating to request: | | | | | |
| PRESCRIBER'S SIGNATURE DA | TE | Albe 1000 | rta Blue Cross, 9-108 Street NV | rd this request to: a Blue Cross, Clinical Drug Services 108 Street NW, Edmonton, Alberta T5J 3C5 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, | | | | | |

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