

DRUG SPECIAL AUTHORIZATION REQUEST

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

PATIENT INFORMATION			•	COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME		INITIAL Alberta Blue Cross Alberta Human Services		
DATE OF BIRTH: YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			- ☐ Other	
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER	
PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME FIRST	T NAME INIT	TAL PRESCR	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
			☐ CPSA ☐ ACO REGISTRATION NUMBER☐ CARNA ☐ ADA+C		
STREET ADDRESS			☐ CARNA ☐ ADA+C		
		PHONE		FAX	
CITY, PROVINCE					
POSTAL CODE		FA	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
☐ NEW ☐ RENEWAL DRUG REQUEST Note: Request may or may not be approved by Alberta Blue Cross					
Drug(s), dosage(s) and duration requested					
Diagnosis and/or indication which drug is being used to treat					
Previous medications and patient response to therapy					
Additional information relating to request					
	1 1				
PRESCRIBER'S SIGNATURE	DATE	Please forward this Alberta Blue	s request to e Cross, Clinical Dru	ug Services	
		10009 108 S	treet NW, Edmontor	n, Alberta T5J 3C5	
				onton • 1-877-828-4106 toll free all other areas	
ONCE YOUR REQUEST HAS SU	CCEQQEIII I V TDANG	SMITTED DIEA	SE DO NOT MAIL	UP BE-EVA AUTO DEULIEGE	

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.



