ALBERTA BLUE CROSS®

ADALIMUMAB/ CERTOLIZUMAB/ ETANERCEPT/ GOLIMUMAB/ INFLIXIMAB/ IXEKIZUMAB/ SECUKINUMAB/ UPADACITINIB for Psoriatic Arthritis

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				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
STREET ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Polyarticular Psoriatic Arthritis

☐ Pauciarticular Psoriatic Arthritis

Joints affected ☐ Knee joints ☐ Hip joints

☐ Other (specify) _____

☐ Other (specify) _____

Indicate requested drug[1]

☐ Abrilada	☐ Cosentyx	☐ Idacio	☐ Simponi
☐ Amgevita	☐ Erelzi	☐ Inflectra	☐ Taltz
☐ Avsola	☐ Hadlima	☐ Renflexis	☐ Yuflyma
☐ Brenzys	☐ Hulio	☐ Rinvoq	
☐ Cimzia	☐ Hyrimoz	☐ Simlandi	

1. For Biosimilar Initiative Exception Requests, please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form

Current weight (kg)

Dosage and frequency

Date of last dose

For patients new to coverage but currently maintained on the requested drug, provide the treatment start date (YYYY-MM-DD) _____

***Pre-treatment scores**		**Current scores**		
DAS28 score ___.____	Date _____	DAS28 score ___.____	**OR** ☐ ACR20 (renewals only)	Date _____
HAQ score ___.___ ___	Date _____	HAQ score ___.___ ___		Date _____

*Requests for patients new to the requested drug and requests for patients new to coverage but currently maintained on the requested drug require pre-treatment scores. All scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places.

Please provide reason if a switch to a different drug is requested

Will the patient be maintained on methotrexate in combination with the requested drug?

☐ YES ☐ NO (If not, please specify reason) _____

Please provide the following information for all NEW requests

Previous medications utilized - dose, duration and response are required for ALL THREE of the following or contraindications, if applicable

☐ Methotrexate PO _____

☐ Methotrexate SC or IM _____

☐ DMARD other than methotrexate (specify agent) _____

For Cosentyx requests only: has the patient had an inadequate response to previous therapy with an anti-TNF alpha agent? ☐ YES ☐ NO

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	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