ALBERTA BLUE CROSS®

ADALIMUMAB/ BIMEKIZUMAB/ ETANERCEPT/ INFLIXIMAB/ IXEKIZUMAB/ RISANKIZUMAB/ SECUKINUMAB/ TILDRAKIZUMAB/ USTEKINUMAB for Plaque Psoriasis

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 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 ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis
☐ Plaque Psoriasis
☐ Other (specify)

Indicate requested drug

Tier 1 Drugs[1,2]

☐ Abrilada	☐ Brenzys	☐ Hadlima	☐ Ilumya	☐ Skyrizi
☐ Amgevita	☐ Cosentyx	☐ Hulio	☐ Inflectra	☐ Taltz
☐ Avsola	☐ [3]Enbrel 25mg/vial	☐ Hyrimoz	☐ Renflexis	☐ Yuflyma
☐ Bimzelx	☐ Erelzi	☐ Idacio	☐ Simlandi	

Tier 2 Drugs[1]
☐ Stelara

1. See p. 2 for SA Criteria Change; 2. For Biosimilar Initiative Exception Requests, please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form

3. Note: all requests for etanercept for patients weighing 63 kg or more will be assessed for coverage with an etanercept biosimilar. Enbrel will be approved for new etanercept starts for pediatric patients weighing less than 63 kg.

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) _____

Location: Prior to treatment with the requested biologic, did the patient have significant involvement of the face, palms of the hands, soles of the feet or genital region?
☐ YES ☐ NO

***Pre-treatment scores**		**Current scores**	
PASI _____	Date _____	PASI _____	Date _____
DLQI _____	Date _____	DLQI _____	Date _____

*Requests for patients new to the requested biologic and requests for patients new to coverage but currently maintained on the requested biologic require pre-treatment scores.
Note: PASI and DLQI scores are required for all requests including those requests for patients that have significant involvement of the face, palms, soles of the feet or genital region.

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

Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Please provide the following information for all NEW requests

Previous medications/therapies utilized - Check all that apply and indicate dose, duration and response, or contraindication, if applicable

☐ Methotrexate PO _____
☐ Methotrexate SC or IM _____
☐ Cyclosporine _____
☐ Phototherapy _____

For TIER 2 drug requests
Please indicate which TIER 1 drugs were tried and the response to therapy, reasons for discontinuation or contraindications, if applicable

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

ALBERTA BLUE CROSS®

ADALIMUMAB/ BIMEKIZUMAB/ ETANERCEPT/ INFLIXIMAB/ IXEKIZUMAB/ RISANKIZUMAB/ SECUKINUMAB/ TILDRAKIZUMAB/ USTEKINUMAB for Plaque Psoriasis

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 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

1. Special Authorization Criteria Change

As of December 12, 2019, tiering will be implemented for biologic drugs for plaque psoriasis. Patients must trial the number of drugs in tier 1 that is equal to the number of different mechanisms of action of the tier 1 drug products prior to accessing a tier 2 drug. Should therapy with a tier 1 therapeutic option(s) fail or be inappropriate due to intolerance or contraindication, access to a more expensive tier 2 agent *may* be considered.

Health Area / Indication	Drugs in Tier 1	Drugs in Tier 2
Dermatology (Plaque Psoriasis)	• Abrilada (adalimumab) • Amgevita (adalimumab) • Avsola (infliximab) • Bimzelx (bimekizumab) • Brenzys (etanercept) • Cosentyx (secukinumab) • Erelzi (etanercept) • Hadlima (adalimumab) • Hulio (adalimumab) • Hyrimoz (adalimumab) • Idacio (adalimumab) • Ilumya (tildrakizumab) • Inflectra (infliximab) • Renflexis (infliximab) • Simlandi (adalimumab) • Skyrizi (risankizumab) • Taltz (ixekizumab) • Yuflyma (adalimumab) *Number of tier 1 drugs that must be trialed: 3*	• Stelara (ustekinumab)

For Tiering Exception Requests

For exception requests for tier 2 drugs for patients already on the requested tier 2 drug

Please provide the date that the tier 2 drug was initiated (YYYY-MM-DD) _____

Please indicate whether the patient is stabilized on the tier 2 drug ☐ YES ☐ NO

Please provide information on the previous method of reimbursement for the tier 2 drug (such as private coverage, compassionate supply)

_____

For exception requests for tier 2 drugs for patients new to the requested tier 2 drug

Please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form.