ALBERTA BLUE CROSS®

CLOPIDOGREL
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
DATE OF BIRTH (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 ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS	PHONE	FAX
CITY , PROVINCE		
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Criteria for Coverage

For the prevention of thrombosis, for one month, when prescribed following intravascular bare metal stent placement. Patients who have received one month of coverage via the Limited Restricted Benefit will not be eligible for additional coverage under this criterion.*

For the prevention of thrombosis, for up to 12 months, when prescribed following intravascular drug eluting stent (DES) placement. Patients who have received one month of coverage via the Limited Restricted Benefit may be eligible for an additional 11 months of coverage (i.e., up to 12 months of coverage) following the submission of a special authorization request.*

For the prevention of ischemic events (cerebrovascular, such as stroke, TIA, or noncerebrovascular) in patients who have experienced an ischemic event while on ASA, or who have a contraindication to ASA. Special Authorization for this criterion may be granted for six months.**

Coverage will not be considered when clopidogrel and ASA/dipyridamole are intended for use in combination.

* Special Authorization for post-stent coverage is required when the prescriber prescribing the medication is not a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery; for treatment after repeat stents; or for continued coverage of up to 12 months following intravascular drug eluting stent (DES) placement.

**This product is eligible for auto-renewal for the third criterion only.

Section I For POST-STENT coverage, indicate the date and type of stent

Date of stenting procedure ______________________________

Type of stent ☐ bare metal stent (one month of coverage) ☐ drug eluting stent (12 months of coverage)

Section II For consideration of additional coverage, complete ALL sections

Please indicate the ischemic event experienced (if applicable)

Cerebrovascular ☐ stroke ☐ TIA Noncerebrovascular (please specify) ______________________________

Please indicate which anti-platelet therapy this patient was on when the ischemic event occurred ☐ ASA ☐ other (please specify) ____________ ☐ Patient was not on anti-platelet therapy

Does this patient have a contraindication/intolerance to ASA? ☐ Yes ☐ No

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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