ALBERTA BLUE CROSS®

TOCILIZUMAB for Giant Cell Arteritis
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	**Dosage & frequency**	**Please indicate if this patient is**
☐ Giant cell arteritis (GCA) ☐ Other (specify)		☐ Starting first treatment course upon approval ……..**complete section I** ☐ Renewal request at 12 to 16 weeks of therapy.....**complete section II** ☐ New to coverage but currently maintained on drug…..**complete sections I and II** ☐ Re-treatment requests .....**complete sections I and III**

Section I: Please complete for all NEW requests for first or subsequent treatment courses (Initial approval for 16 weeks)

1) The current tocilizumab treatment course will be (or was) initiated in combination with a glucocorticoid?
- ☐ Yes → specify glucocorticoid _____
- ☐ No → indicate reason(s) _____

2) If the patient is currently on tocilizumab, indicate start date of treatment course (YYYY-MM-DD) _____

3) For coverage, tocilizumab must be initiated in consultation with a specialist in internal medicine, rheumatology or neurology.
Please indicate the specialist consulted for the current treatment course, where applicable _____

Section II: Please complete for RENEWAL requests at 12 to 16 weeks of therapy (Renewal approval for 36 weeks)

4) Has the patient's disease flared* while on tocilizumab? ☐ Yes ☐ No

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

5) Has the patient's C-reactive protein (CRP) normalized to <1 mg/dL (<10 mg/L)?
- ☐ Yes → indicate CRP level _____ mg/dL (or _____ mg/L) and date (YYYY-MM-DD) _____
- ☐ No → explain _____

Section III: Please complete for RE-TREATMENT requests

6) Provide the date of discontinuation of the previous tocilizumab treatment course (YYYY-MM-DD) _____

7) Has the patient's disease flared* **after discontinuation** of treatment with tocilizumab?
- ☐ Yes
- ☐ No → explain _____

*Flare is defined as the recurrence of signs or symptoms of GCA and/or erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr attributable to GCA.

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