ALBERTA BLUE CROSS®

BIOSIMILAR INITIATIVE / TIERING EXCEPTION 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

NOTIFICATION

You may be eligible to receive the requested drug benefits. Information from your prescriber is collected for the sole purpose of determining eligibility for drug coverage. Your consent is required: (A) for your prescriber to release necessary and relevant information to Alberta Blue Cross, to Alberta Health, to Alberta Human Services (if requested) for the Biosimilar Initiative/Tiering exception; and (B) for Alberta Blue Cross to release that to Alberta Health and the reviewing specialists. The information will be shared with the specialists who review the request for coverage. In addition, related usage information may be released to Alberta Health.

PATIENT CONSENT

I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health, Alberta Human Services (if they request it); and (B) Alberta Blue Cross to release to Alberta Health and the specialists who review the request, the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.

Date (YYYY-MM-DD) Patient's signature

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

Indicate requested drug for a) OR b)		Diagnosis (please specify)	Dosage
a) Request for originator as biosimilar cannot be used Please specify requested originator _____	**b) Exception is required for tier 2 drug** Please specify requested tier 2 drug _____	**For Remicade and Stelara requests only: Current weight (kg)** **For Rituxan requests for GPA/MPA only: Body surface area (m^2)**	**Frequency**

Please provide additional documentation for the following in order for the exception request to be considered:

1. Please provide summary of clinical status and disease course: *Please include ALL applicable clinical assessment scores*
2. Please provide previous / current medications used: *Please indicate when the medications were used, dose, duration of use and response to each treatment*
3. Please provide rationale for Exception Request: *Clearly indicate the reason(s) why patient is unable to switch to the biosimilar or is unable to use the tier 1 drugs*
4. Please provide information as to whether the patient has tried the biosimilar or prerequisite number of tier 1 drugs:
   a) If so, please provide the duration of the trial and nature of response (provide scores to indicate biosimilar was not effective if applicable, laboratory values (e.g. A1c changes for insulin glargine while on biosimilar), detailed documentation to include frequency and severity of adverse effects (e.g. for insulin glargine: provide hypoglycemic or hyperglycemic events per week, A1c change while on biosimilar versus while on originator))
   b) If not, please provide additional clinical information relating to patient's condition (e.g. for Crohn's, the number and date of any intestinal resections, include any underlying, diagnosed co-morbidities that preclude use of the biosimilar, and indicate if such co-morbidities are well controlled or being managed)

If the reason for exception request is pregnancy, indicate if patient is currently pregnant ☐ Yes, anticipated due date ☐ 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.