ALBERTA BLUE CROSS®

HALOBETASOL PROPIONATE + TAZAROTENE TOPICAL LOTION 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
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
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

Criteria for coverage

"Special authorization coverage may be provided for improving the signs and symptoms of moderate to severe plaque psoriasis in adult patients (18 years of age and older) who meet ALL of the following criteria:

1) Patients must have a clinical diagnosis of plaque psoriasis with all of the following characteristics:
   - an Investigator's Global Assessment (IGA) score of 3 (moderate) or 4 (severe), and
   - an area of plaque psoriasis appropriate for topical treatment covering a body surface area (BSA) of 3% to 12%, and
2) Patients must have not adequately responded to a topical high-potency corticosteroid and for whom the addition of a second topical medication would be appropriate.

Initial coverage may be approved for 12 weeks.

For continued coverage beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by the prescriber after the initial 8 to 12 weeks of therapy to determine response.
2) The prescriber must confirm, in writing, that the patient is a 'responder' with an IGA score of 'clear' or 'almost clear' (0 or 1).

Continued coverage may be granted for 12 months."

The product is eligible for auto-renewal after continued coverage criteria have been met.

Please provide the following information for ALL requests

Diagnosis

☐ Moderate to severe plaque psoriasis ☐ Other (please specify) _____

Please provide the following information for all INITIAL requests for treatment-naive and treatment-experienced patients

1) The patient has an area of plaque psoriasis appropriate for topical treatment covering a body surface area (BSA) of 3% to 12%	☐ Yes	☐ No
2) The patient has not adequately responded to a topical high-potency corticosteroid and the addition of a second topical medication is appropriate	☐ Yes	☐ No

3) **Pre-treatment** Investigator's Global Assessment (IGA) score _____ and Date _____

Please provide the following information for RENEWAL requests and for INITIAL requests for treatment-experienced patients

4) **Current** Investigator's Global Assessment (IGA) score _____ and Date _____

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.