

DUPILUMAB For Atopic Dermatitis 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								COVER	AGE TYPE			
LAS	T NAME	FIRST NAME				INITIAL		☐ Alberta Blue Cross				
BIR	RTH DATE (YYYY-MM-DD) ALBERTA PERSONAI				 HEALTH NUMBER				☐ Alberta Human Services			
Direct	ALBERTAT ENGUAL				LALITINOMBLIC				☐ Other			
ADD	RESS	CITY PROV			POSTAL CODE		ODE	ID/CLIENT/COVERAGE NUMBER		NUMBER		
DDE	SCRIPER INFORMATION											
PRESCRIBER INFORMATION PRESCRIBER LAST NAME FIRST NAME INITIAL PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION												
						☐ CPSA ☐ ACO REGISTRATION NUMBER						
						☐ CARNA ☐ ADA+C						
□ ACP							Other					
CITY, PROVINCE					PHONE				FAX			
POSTAL CODE												
POSTAL CODE FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED												
Please provide the following information for ALL requests												
Diagnosis					Dosage and frequency					Current weight		
☐ Moderate to severe atopic dermatitis (kg)										(kg)		
Other (please specify)												
Combination therapy												
Will the requested drug be used in combination with phototherapy or immunomodulating drugs ☐ Yes ☐								□ No				
For patients new to coverage but currently maintained on the requested drug, provide the treatment start date												
Please provide the following <u>pre-treatment</u> information for NEW requests for treatment-naïve and treatment-experienced patients												
1) Pre-treatment Investigator's Global Assessment (IGA) score and Date												
2)												
3)	Previous medications/therapies utilized - Check all that apply and indicate dose, duration and response to each, or indicate contraindication, if applicable											
	☐ Topical corticosteroid											
	☐ Topical calcineurin inhibitor											
	☐ Conventional systemic immunomodulatory drugs (specify at least <u>TWO</u> steroid-sparing agents)											
	Agent #1:											
	Agent #2:											
	☐ Phototherapy											
Please provide the following information for RENEWAL requests and INITIAL requests for treatment experienced patients												
Current Eczema Area and Severity Index (EASI) score and Date												
Additional information relating to request												
PRESCRIBER'S SIGNATURE D		ATE (YYYY-MM-DD)			ard this request to							
			100	Alberta Blue Cross, Clinica 10009 108 Street NW, Edmo FAX 780-498-8384 in I			dmonton	, Alberta	T5J 3C5	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.

©*The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross Plans. Licensed to ABC Benefits



