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|  | ENHANCED SPECIAL  AUTHORIZATION REQUEST:  Psoriatic Arthritis |

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| **INSTRUCTIONS:**   1. Please have your physician indicate whether this is an **INITIAL** enhanced special authorization request, a medication **CHANGE** request or a **RENEWAL** request by checking the appropriate box below and then completing **ONLY** the noted sections. 2. Part 2 must be completed by a specialist in the area of treatment. 3. Please be aware that as the covered member, you are responsible for any fees charged by your physician/specialist for the completion of this form. Form fees for enhanced special authorization requests are not covered by your plan. 4. Please have your physician submit the completed form to the Alberta School Employee Benefit Plan (ASEBP) by fax at 1-888-895-6837 or by email at [SpecAuthHS@asebp.ca](mailto:SpecAuthHS@asebp.ca). 5. If you or your physician have any questions about the enhanced special authorization process, please contact Clinical Services at 780-431-4780. |

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| **TYPE OF REQUEST:** | | |
| Initial  (complete Part 1, Part 2 A-E, plus physician signature) | Change  (complete Part 1, Part 2 A-E, plus physician signature) | Renewal  (complete Part 1, Part 2 A and F, plus physician signature) |

**Part 1: Patient Information** *(to be completed by* ***patient****)*

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| A. Patient Information | | | | | | |
| Last name: | First name: | | | | | ASEBP ID: |
| Address: | | | | | Date of birth (YYYY/MM/DD): | |
| City: | | Province: | | | Postal code: | Phone: |
| School jurisdiction (if patient is the covered member): | | | | If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: Spouse  Dependant | | |
| **NOTE:** Important notifications about your renewal will ***only*** be sent to the covered member email address used to register with My ASEBP. To register, visit [www.asebp.ab.ca/MyASEBP/](http://www.asebp.ab.ca/MyASEBP/) and follow the prompts. | | | | | | |
| **Coordination of Benefits** | | | | | | |
| Do you or your dependants have prescription drug coverage through another health benefits company, insurance company or another ASEBP plan?  Yes  No  If yes, please complete below. | | | | | | |
| Name of other health benefits company or insurance company: | | | Name of person holding coverage: | | | |
| Effective date of other coverage (YYYY/MM/DD): | | | Coverage holder date of birth (YYYY/MM/DD): | | | |

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| **Have you previously applied for funding or support from the manufacturer/patient assistance program for this medication?**  Yes  No  Please provide details and attach documentation of approval or declination:    The manufacturer/patient assistance program may have information which will be useful for your enhanced special authorization request, such as the verification of health and claims information related to your request. May ASEBP contact the manufacturer/patient assistance program to discuss or collect information related to your enhanced special authorization request?  Yes  No |

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| B. Consent to Collection, Use and Disclosure of Personal Health Information | | | |
| The personal information contained in this form (with any supporting documentation provided) and other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility for this benefit, to provide you with information regarding additional resources available to you through your benefits (e.g., Employee Family Assistance Program, Apple-a-Day) and administer the benefit plan. It may be necessary for ASEBP to disclose your personal information related to this notification to a third party service provider. When third party service providers are retained, appropriate contracts are in place to protect personal information.  I authorize my prescribing physician, pharmacist and/or the manufacturer/patient assistance program (if ‘yes’ was selected in the applicable area of the Coordination of Benefits section above) to disclose to ASEBP the information noted herein and any further information requested by ASEBP for the purpose of managing this enhanced special authorization request.  I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my/our eligibility to receive benefits related to this special authorization request.  I agree this authorization shall be in effect from the date below and shall be valid for the duration of time required to manage this request.  I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.  I agree to the above and declare that my statements in this form are complete, accurate and true.  **Verbal consent will not be accepted, form must be signed by patient or parent/guardian.**  Patient signature: “First name Last name” Date:  If patient is a minor, parent/guardian signature: “First name Last name”  *Consent is obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act (PIPA) of Alberta and section 1 of the federal Personal Information Protection Electronic Documents Act. Be advised that in order to optimize the services we provide, we may use service providers outside Canada to carry out certain functions on our behalf. In such situations, we enter into contracts and/or verify that appropriate privacy and security protocols are in place. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP’s Privacy Policy at asebp.ca or contact the privacy officer at 780-438-5300.* | | | |
| Part 2: Clinical Information *(to be completed by prescribing physician; must be a specialist in area of treatment)* | | | |
| A. Prescriber Information | | | |
| Prescriber name: | | CPSA #: | |
| Address: | | Specialty: | |
| City: | Province: | Phone: | Fax:  *Fax number must be provided with each request submitted.* |
| Postal code: | |

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| B. Medication Requested | |
| INITIAL ONE-YEAR COVERAGE for the treatment of psoriatic arthritis. | |
| Drug name requested: | Is the patient currently on this medication? Yes; start date:        No |
| Drug strength(s): Please specify if titration is required and drug strengths necessary. | Directions for use (frequency or schedule, if appropriate (e.g., at 0, six, eight weeks, etc.): |
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| C. Clinical Information | | | |
| Diagnosis:    Is this medication for an off-label use?  Yes  No | Date of initial diagnosis:  Month       Year | | Anticipated duration for treatment (max. approval is for one year): |
| Does patient have any relevant drug allergies?  Yes  No | Nature of allergy, if applicable: | | Current patient weight: |
| **Scores**  DAS28 Score:      -      Date:       ***AND***  HAQ Score:      -      Date: | | Affected joints:  Knee(s)  Hip  Other:  Number of swollen joints: | |
| Will the patient be maintained on methotrexate (MTX) in combination with the requested biologic?  Yes  No (if not, please specify reason): | | | |
| Please provide all relevant clinical information to support medical necessity of drug therapy requested including any relevant lab tests which may support choice/monitoring of drug therapy. Please attach radiographic evidence of psoriatic arthritis.    Lab tests attached/scanned:  Yes  No | | | |
| Please scan/attach any additional information that may be relevant in atypical cases that support the drug therapy choice. | | | |

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| D. Criteria for Initial Coverage | | | | |
| DMARD utilization (Current and previous, including any prior biologics) | | | | |
| Drug Name | Dosing Regimen | Start Date(YYYY/MM) | End Date(YYYY/MM) | Patient Response (if discontinued, provide details of intolerance, contraindication, or failure at maximum dose) |
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| If a **switch** to a **different biological agent** is requested, please provide reason: | | | | |
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| E. All Other Medical Conditions and Drug Therapies Relevant to Your Health State | | |
| Condition/Diagnosis | Date Diagnosed(YYYY/MM) | Current Medications |
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| F. Renewal Coverage Criteria | | | | | | | | |
| Requested drug, dose and interval:  Drug name:  Dose:       mg  Interval: | | Date patient started current biologic:  Month  Year | | | Anticipated duration for treatment (max. approval is one year): | | Current patient weight: | |
| **Scores**  DAS28 score:      -      *or* ACR20:      -      Date:  ***OR***  HAQ score:      -      Date: | | | | Affected joints:  Knee(s)  Hip  Other:  Number of swollen joints: | | | | |
| Concurrent DMARD therapy:    *OR*  Mark here if none | Drug | | Dose | | | Route | | Frequency |
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| Please provide any additional comments regarding patient’s current medical status as applicable: | | | | | | | | |
| Please provide details explaining a lapse, for any period of more than 120 days, of the request medication during the previous approval period. | | | | | | | | |

**Please be advised further information may be requested if needed to facilitate determination of coverage.**

Complete requests will be processed within five business days. However, should your patient’s condition require hospitalization, please contact Clinical Services at 780-431-4780 for same-day processing.

**Please note that administering a compassionate (bridge) dose to a covered member without prior authorization from ASEBP does not guarantee continued coverage, which is based on our eligibility criteria.**

Prescribing physician signature: “First name Last name” Date: