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www.asebp.ca

# ENHANCED SPECIAL AUTHORIZATION REQUEST: Psoriasis

## INSTRUCTIONS:

1. Please note that this form is to only be used by ASEBP covered members and their dependants. Members of the ARTA Retiree Benefits Plan do not need to use this form.
2. 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.
3. Part 2 must be completed by a specialist in the area of treatment.
4. Please have your physician submit the completed form to ASEBP by fax at 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 our ASEBP Specialty Claims Coordinator at 780-431-4780.

## TYPE OF REQUEST:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Initial<br>(complete Part 1, Part 2 A-E, plus<br>physician signature) | <input type="checkbox"/> Change<br>(complete Part 1, Part 2 A-E, plus<br>physician signature) | <input type="checkbox"/> Renewal<br>(complete Part 1, Part 2 A and F, plus<br>physician signature) |
|--|---|--|

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

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: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant	
<b>NOTE:</b> Important notifications about your renewal will <i>only</i> be sent to the covered member email address used to register with My ASEBP. To register, visit <a href="http://www.asebp.ca/MyASEBP/">www.asebp.ca/MyASEBP/</a> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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):	

**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

## **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: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor, parent/guardian signature: \_\_\_\_\_

*Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta, Schedule 1 of the federal Personal Information Protection Electronic Documents Act and, in relation to personal health information, section 34 of the Health Information Act of Alberta. If you have any questions regarding the collection, use or disclosure of your personal information, please refer to our website at [www.asebp.ca](http://www.asebp.ca) or contact the Privacy Officer at [po@asebp.ca](mailto:po@asebp.ca) or 780-438-5300.*

## **Part 2: Clinical Information (to be completed by prescribing physician; must be a specialist in area of treatment)**

<b>A. Prescriber Information</b>			
Prescriber name:		CPSA #:	
Address:		Specialty:	
City:	Province:	Phone:	Fax:
Postal code:		<i>Fax number must be provided with each request submitted.</i>	

## B. Medication Requested

INITIAL ONE-YEAR COVERAGE for the treatment of moderate to severe plaque psoriasis.

Drug name requested:	Is the patient currently on this medication? <input type="checkbox"/> Yes; start date: ____/____/____ <input type="checkbox"/> 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.):

## C. Clinical Information

Diagnosis:	Date of initial diagnosis: Month _____ Year _____	Anticipated duration for treatment (max. approval is one year):
Is this medication for an off-label use? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have any relevant drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature of allergy, if applicable:	Current patient weight:
<b>Scores</b> Current Psoriasis Area Severity Index (PASI): _____ Date: ____/____/____ OR Dermatology Life Quality Index (DLQI): _____ Date: ____/____/____		% body surface area (BSA):  Areas of body involved:
Will the patient be maintained on methotrexate (MTX) in combination with the requested biologic? <input type="checkbox"/> Yes <input type="checkbox"/> 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:  Lab tests attached/scanned: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please scan/attach any additional information that may be relevant in atypical cases that support the drug therapy choice.		

## D. Criteria for Initial Coverage

Prior/current medication therapies (including ALL immunosuppressants, prior biologics, steroids and topical medications)

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)
		/	/	
		/	/	
		/	/	
		/	/	

UV phototherapy:  Failed to respond  Intolerant  Unable to access  Did not attempt

If a **switch** to a **different biological agent** is requested, please provide reason:

E. All Other Medical Conditions and Drug Therapies Relevant to Your Health State		
Condition/Diagnosis	Date Diagnosed (YYYY/MM)	Current Medications
	/	
	/	
	/	
	/	

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:
Pre-biologic PASI score: _____			
Current PASI score: _____			
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.

Prescribing physician signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_