ALBERTA BLUE CROSS™

DRUG SPECIAL AUTHORIZATION REQUEST

Please ensure that all sections are completed to allow your request to be processed.

PATIENT INFORMATION

PATIENT NAME Surname / First / Initial	DATE OF BIRTH Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

COVERAGE TYPE

☐ Alberta Blue Cross ☐ Alberta Family & Social Services

☐ Veterans Affairs Canada ☐ Other:

CARDHOLDER NAME:
(If different than patient)

IDENTIFICATION / CLIENT / COVERAGE NUMBER:

PHYSICIAN INFORMATION

PHYSICIAN NAME Surname / First / Initial	ALBERTA REGISTRATION NO.	TELEPHONE / FAX NUMBERS
		Phone: FAX:

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

DRUG REQUEST Note: Request may or may not be approved by Alberta Blue Cross

Drug(s), Dosage(s) and Duration Requested:

Diagnosis and / or Indication Which Drug Is Being Used To Treat: (Include applicable information regarding previous medications, patient response to therapy and proposed results of therapy.)

Additional Information Relating to Request:

PHYSICIAN'S SIGNATURE	DATE	Please forward white copy of this request to: **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009 - 108 Street NW, Edmonton, Alberta T5J 3C5** FAX Number: **(403) 498-8384**

THIS SECTION IS FOR ALBERTA BLUE CROSS USE ONLY

ELIGIBILITY	OUTCOME
	SYSTEM ENTRY
SIGNATURE & DATE	

ABC 20061 (R95/09)

PLEASE RETAIN THE YELLOW COPY OF THIS REQUEST FOR YOUR RECORDS.