ALBERTA BLUE CROSS®

EZETIMIBE
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:**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NO.
STREET ADDRESS			PHONE: / FAX:
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of EZETIMIBE

For the treatment of hypercholesterolemia in patients who are intolerant to statins or in whom a statin is contraindicated and who are at high cardiovascular risk*, or;

For the treatment of hypercholesterolemia when used in combination with a statin in patients failing to achieve target LDL with a statin at maximum tolerable dose or maximum recommended dose as per respective product monograph and who are at high cardiovascular risk*

Special authorization may be granted for 6 months. This product is eligible for auto-renewal.

****High cardiovascular risk is defined as possessing one of the following:***

1) ***pre-existing cardiovascular disease and/or cerebrovascular disease, or***
2) ***diabetes, or***
3) ***familial hypercholesterolemia, or***
4) ***greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool, OR***
5) ***three or more of the following risk factors:***
   - ***family history of premature cardiovascular disease***
   - ***smoking***
   - ***hypertension***
   - ***obesity***
   - ***glucose intolerance***
   - ***renal disease.***

☐ **NEW** **Please provide the following information for all NEW requests:**

A. Diagnosis: ☐ hypercholesterolemia ☐ other, please specify _____

B. Information regarding previous STATIN use:

☐ Statin(s) HAS been utilized. Please specify which statin has been utilized (including dose and duration): _____

Nature of response to STATIN: ☐ Intolerance ☐ Failure to achieve target LDL ☐ Other _____

☐ Statin(s) has NOT been utilized. Contraindication? ☐ Yes ☐ No Please elaborate: _____

C. Presence of CARDIOVASCULAR risk factors (CHECK ALL THAT APPLY):

*In order to comply with the above criteria check **at least three** of the following:*

☐ family history of premature cardiovascular disease ☐ smoking ☐ hypertension ☐ obesity ☐ glucose intolerance ☐ renal disease

AND/OR

*In order to comply with the above criteria check **at least one** of the following:*

☐ pre-existing cardiovascular disease and/or cerebrovascular disease ☐ diabetes ☐ familial hypercholesterolemia

☐ greater than or equal to 20% risk as defined by the Framingham Risk Assessment Tool

D. Additional information relating to request:

☐ **RENEWAL**

This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).
Please indicate response to therapy:

PRESCRIBER'S SIGNATURE	DATE	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.