ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

DUTASTERIDE/FINASTERIDE SPECIAL AUTHORIZATION REQUEST FORM

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 REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	
STREET ADDRESS	PHONE:	FAX:
CITY , PROVINCE		
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Indicate which drug is requested (check one box): ☐ Dutasteride ☐ Finasteride

Criteria for Coverage of DUTASTERIDE / FINASTERIDE

For the treatment of benign prostatic hyperplasia in patients who are poor surgical risks or who have enlarged prostates and have moderate to severe symptoms suggestive of obstruction.
Special authorization may be granted for 6 months. This product is eligible for auto-renewal.

☐ **NEW Please provide the following information for NEW requests (Section 1, AND Section 2 or 3 must be completed):**

Section 1: Diagnosis:

☐ Benign Prostatic Hyperplasia ☐ Other (specify): ____

Section 2: Surgical Risk:

Is the patient a poor surgical risk? → ☐ no ☐ yes

If yes, please **specify** any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:

Has this patient had surgical intervention (TURP) for this condition in the past?

☐ yes ☐ no

Section 3: Enlarged Prostate:

Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction?

☐ yes

☐ no

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.

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.

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