

## DUTASTERIDE/FINASTERIDE 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.

PATENT LAST NAME       FIRST NAME       INITIAL       Aborta Blue Oroal         DATE OF BIRTH: Year / Month / Day       ALBERTA PERSONAL HEALTH NUMBER       Other         STREET ADDRESS       CITY       PROV       POSTAL CODE       IDENTFICATION/CLENT/COVERAGE No:         PRESCRIBER INFORMATION       PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION       REGISTRATION NO.         CACANA       ADA-C       CPSA       ACO         CITY       PROV       POSTAL CODE       IDENTFICATION/CLENT/COVERAGE No:         STREET ADDRESS       CITY       PROV       POSTAL CODE       REGISTRATION NO.         CACANA       ADA-C       CPSA       ACO       CACANA       ADA-C         OTTY . PROVINCE       PROVINCE       FAX. NUMBER MUST BE PROVIDED WITH EACH         Indicate which drug is requested (check one box):       Dutasteride       Finasteride         Criteria for Coverage of DUTASTERIDE / FINASTERIDE       FOR the trastment 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.         Section 1: Diagnosis:       Image: Section 1: AND Section 2 or 3 must be completed):       Section 3: Enlarged Prostate:         If yes, please Specify any underlay in medical condition (s) or other circumstances by which this patient have enlarged prostate:       Section 3: Enlarged Prostate:	PATIENT INFORMATION						COVERAGE TYPE:		
DATE OF BIRTH: Year / Month / Day       ALBERTA PERSONAL HEALTH NUMBER         STREET ADDRESS       CITY       PROV       POSTAL CODE       IDENTIFICATION/CLENT/COVERAGE No:         PRESCRIBER INFORMATION       PRESCRIBER INFORMATION       PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION NO.       CASA         STREET ADDRESS       CPSA       ACC       REGISTRATION NO.         CARP       Other       PROV       POSTAL CODE       REGISTRATION NO.         CITY, PROVINCE       PHONE:       FAX:       FAX:         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.       Section 1, AND Section 2 or 3 must be completed):         Section 2: Surgical Risk:       Interpresenter approximation for NEW requests (Section 1, AND Section 2 or 3 must be completed):       Section 3: Enlarged Prostate:         Does this patient have enlarged intervention (TURP) for this condition in the past?       Does this patient have enlarged prostate: Does this patient have enlarged prostates and hothe drug product during the Approval Period. <td>PATIENT LAST NAME</td> <td colspan="5">FIRST NAME INITIAL</td> <td colspan="2">Alberta Human Services</td>	PATIENT LAST NAME	FIRST NAME INITIAL					Alberta Human Services		
PRESCRIBER INFORMATION       PRESCRIBER INFORMATION         PRESCRIBER LAST NAME       FIRST NAME       INITIAL       PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION         STREET ADDRESS	DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER					C Othe	r	
PRESCRIBER INFORMATION       PRESCRIBER INFORMATION         PRESCRIBER LAST NAME       FIRST NAME       INITIAL       PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION         STREET ADDRESS	STREET ADDRESS	CITY							
PRESCRIBER LAST NAME       FIRST NAME       INITIAL       PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION         CPSA       ACO       REGISTRATION NO.       CRAIN       ADA+C         CITY , PROVINCE       FAX:       FAX:         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 being 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.         Section 1: Diagnosis:       Other (specify):       Section 2 or 3 must be completed):         Section 2: Surgical risk? -> no yes							10 E I I II		
CPSA       ACO       REGISTRATION NO.         STREET ADDRESS       ACP       Other         PHONE:       FAX:         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.       Section 1: Diagnosis:         Benign Prostatic Hyperplasia       Other (specify):         Section 2: Surgical Risk:       Section 3: Enlarged Prostate: Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction.         If yes, please specify any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:       Section 3: Enlarged Prostate: Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction?         If yes, please specify any underlying the queuest is required only if the Special Authorization approval has lapsed (i.e. the patient has gramed as clain for the drug product during the Approval Period).         Has this patient had surgical intervention (TURP) for this condition in the past?       In the patient has gramed as clain for the drug product during the Approval Period).	PRESCRIBER INFORMATION								
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Section 1: Diagnosis:         Benign Prostatic Hyperplasia       Other (specify):	have moderate to severe symptoms suggestive of obstruction.								
□ Benign Prostatic Hyperplasia       □ Other (specify):	NEW Please provide the following information for NEW requests (Section 1, AND Section 2 or 3 must be completed):								
Section 2: Surgical Risk:       Image: Section 3: Enlarged Prostate:         Is the patient a poor surgical risk? → no yes       Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction?         If yes, please specify any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:       Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction?         Image: Has this patient had surgical intervention (TURP) for this condition in the past?       Image: Ima	Section 1: Diagnosis:								
Is the patient a poor surgical risk? → □ no □ yes       Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction?         If yes, please specify any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:       Does this patient have enlarged prostate with moderate to severe symptoms suggestive of obstruction?         Has this patient had surgical intervention (TURP) for this condition in the past?       yes       no         Additional information relating to request       In no       In no         Additional information relating to request       PRENEWAL         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:       PressCRIBER'S SIGNATURE       DATE       Please forward this request to: • Alberta Blue Cross, Clinical Drug Services 1009-108 Street NW, Edmonton , Alberta T5J 3C5 • FAX: 780-48-384 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.	Benign Prostatic Hyperplasia Other (specify):								
If yes, please specify any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:       prostate with moderate to severe symptoms suggestive of obstruction?         If yes, please specify any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:       prostate with moderate to severe symptoms suggestive of obstruction?         Image: the second	Section 2: Surgical Risk:						Sect	ion 3: Enlarged Prostate:	
If yes, please specify any underlying medical condition(s) or other circumstances by which this patient would be deemed a poor surgical risk:       symptoms suggestive of obstruction?         which this patient would be deemed a poor surgical risk:       yes         Has this patient had surgical intervention (TURP) for this condition in the past?       yes         yes       no         Additional information relating to request       in no         Additional information relating to request       sequence         Please indicate response to therapy:       Please forward this request to:         • Alberta Blue Cross, Clinical Drug Services       • Alberta T5J 3C5         • FAX: 780-498-8384 in Edmonton , 1-877-828-4106 toll free all other areas         ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.									
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program or recent a contract of program of the and the second of the sec	program or receive a benefit, product or health service. If you have any questions regarding								

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