ALBERTA BLUE CROSS®

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

MONTELUKAST/ZAFIRLUKAST
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): ☐ **Montelukast** (5mg + 10mg) ☐ **Zafirlukast** (20mg)

Criteria for Coverage of MONTELUKAST / ZAFIRLUKAST

For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:

a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, OR

b) cannot operate inhaler devices.

For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists.

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

Note: Refer to the Alberta Drug Benefit List for Restricted Benefit coverage of patients 2 to 18 years of age inclusive for Montelukast and 12 to 18 years of age inclusive for Zafirlukast.

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

Section 1: Indication:

☐ Prophylaxis and chronic treatment of asthma (If yes, proceed to Section 2A or 2B only).
☐ Prophylaxis of exercise-induced bronchoconstriction (If yes, proceed to Section 3 only).
☐ Other (specify): _____

Section 2: Prophylaxis and chronic treatment of asthma:

A. Previous Medication Use:

a) Please indicate if an inhaled glucocorticosteroid was used:
☐ Yes ☐ No (If no, specify reason):_____

b) Please indicate if a long-acting beta 2 agonist (e.g. salmeterol or formoterol) was tried:
☐ Yes → Response: ☐Persistent symptoms
☐ Other (specify)_____
☐ No (If no, specify reason):_____

B. Use of Inhaler Device

Please indicate if the patient has difficulty using an inhaler device:
☐ Yes (Please elaborate on the nature of the difficulty)_____
_____
☐ No

Section 3: Prophylaxis of exercise induced bronchoconstriction:

Does this patient have tachyphylaxis with long-acting beta 2 agonists? ☐ Yes ☐ No ☐ Other (specify): _____

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.