ALBERTA BLUE CROSS®

OMALIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other

STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

SPECIALIST IN RESPIROLOGY OR CLINICAL IMMUNOLOGIST INFORMATION

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

Please provide the following information for ALL requests:

Diagnosis: ☐ Severe Asthma → a) Most recent date of confirmation of diagnosis :____________________

b) Has the patient been under your care > 1 year? ☐YES ☐NO

☐ Other (specify):

Current weight (kg):

☐ Smoker ☐ Non-Smoker

Provide the following pre-treatment information for NEW requests for treatment naive and treatment experienced patients:

Total serum human immunoglobulin (IgE) (IU/ml)	Date	AQLQ – Juniper Score		Date
☐ Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing	Date	ACQ-5 Scores	Score #1	Date
FEV1 (pre-bronchodilator % predicted)	Date		Score #2	Date

Number of exacerbations of asthma within the previous 12 month period prior to starting omalizumab that resulted in:

An Emergency Room visit / Hospitalization: ______________ Unscheduled physician visits resulting in oral corticosteroids: ______________

Please check one of the following :

☐ One or more severe exacerbations of asthma requiring a hospital admission or Emergency Room visit within the previous year while on systemic corticosteroids: **OR**

☐ One or more severe exacerbations of asthma requiring a hospital admission or Emergency Room visit requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids); **OR**

☐ Three or more severe exacerbations of asthma within the previous year, which required an unscheduled physician visit and resulted in courses (or chronic use >50% of the year) of systemic corticosteroids.

Previous medications utilized: Name of Medication, dose, duration and response is required for **ALL** of the following:

☐ High-dose inhaled corticosteroids :

☐ Long-acting beta-2 agonists :

☐ Oral corticosteroids :

Chronic use (>50% of the year) of oral corticosteroids? YES☐ NO☐

Provide the following information for all RENEWAL requests and for INITIAL requests for treatment experienced patients:

Current FEV1 (pre-bronchodilator % predicted)	Date	Current AQLQ – Juniper Score	Date	Current ACQ-5 Score	Date

Number of exacerbations of asthma within the previous 12 month period while on omalizumab that resulted in:

An Emergency Room visit / Hospitalization: ______________ Unscheduled physician visits resulting in oral corticosteroids: ______________

Please check ALL of the following that apply :

☐ Patient demonstrated at least a 25% reduction in the number of exacerbations, which required oral corticosteroids from the 12 months prior to initiation of omalizumab that required systemic corticosteroids.

☐ For patients that were on chronic (>50% of the year) courses of oral corticosteroids use in the prior 12 months to initiation of omalizumab, tapering of oral corticosteroid use by at least 25% from baseline.

☐ A reduction in the number of exacerbations that have led to a hospital admission or emergency room visits, compared to the 12 months prior to the commencement of omalizumab.

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 collected by this form is collected 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 purpose 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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