ALBERTA BLUE CROSS®

FILGRASTIM / PEGFILGRASTIM / PLERIXAFOR 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
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested (check ONE box)

- ☐ **[1]Fulphila (pegfilgrastim) → complete Section I only**
- ☐ **[1]Grastofil (filgrastim) → complete Section I or II**
- ☐ **[1]Lapelga (pegfilgrastim) → complete Section I only**
- ☐ **[1]Neulasta (pegfilgrastim) → complete Section I only**
- ☐ **[1]Neupogen (filgrastim) → complete Section I or II**
- ☐ **Plerixafor (e.g. Mozobil) → complete Section III only**
- ☐ **[1]Ziextenzo (pegfilgrastim) → complete Section I only**

1. See p. 2 for Biosimilar Switch Policy

Section I (Filgrastim requests for the first criterion and all pegfilgrastim requests, check ALL that apply)

a) Please **SPECIFY** the type of cancer being treated with chemotherapy for curative intent _____

b) Please provide the indication for which the drug is requested

- ☐ patient has febrile neutropenia
- ☐ patient had febrile neutropenia from a previous cycle of the same chemotherapy
- ☐ patient will be undergoing a *high dose* or *aggressive* chemotherapy where febrile neutropenia is very likely to occur
- ☐ other (please **SPECIFY)** _____

Section II (Filgrastim requests for other criteria, check ALL that apply)

a) Please provide the indication for which filgrastim is requested

- ☐ patient has neutropenia AND a diagnosis of ☐ congenital, cyclic or idiopathic neutropenia OR ☐ acute myeloid leukemia
- ☐ other, please **SPECIFY** _____

Section III (Plerixafor requests, check ALL that apply)

a) Please provide the patient's current weight (kg) _____

b) Please **SPECIFY** the type of cancer being treated

- ☐ multiple myeloma (MM) ☐ Non-Hodgkin's lymphoma (NHL) ☐ other, please **SPECIFY** _____

c) Please provide the indication for which the drug is requested

- ☐ patient is undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy
- ☐ other (please **SPECIFY)** _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	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

ALBERTA BLUE CROSS®

FILGRASTIM / PEGFILGRASTIM / PLERIXAFOR SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

1. Biosimilar Switch Policy

As of December 12, 2019, patients using an originator biologic for which there is a biosimilar treatment option for their indication and who wish to maintain Alberta Health coverage of the molecule will be required to switch to the biosimilar by January 15, 2021. During the transition period from December 12, 2019 to January 14, 2021, Alberta Health will cover both the originator biologic and the biosimilar(s) of the affected drug(s). Effective January 15, 2021, Alberta Health will only cover the biosimilar versions of the drugs listed below, for the affected indications.

Drug	Originator (Switch from)	Biosimilar (Switch to)	Indication
Filgrastim	Neupogen	Grastofil	Neutropenia
Pegfilgrastim	Neulasta	Fulphila or Lapelga or Ziextenzo	Neutropenia

For Biosimilar Initiative Exception Requests

Please complete the Biosimilar Initiative / Tiering Exception Special Authorization Request Form.

FILGRASTIM (e.g. Grastofil, Neupogen) special authorization criteria

"In patients with non-myeloid malignancies, receiving myelosuppresive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia."

"Following induction and consolidation treatment for acute myeloid leukemia, for the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization."

"In patients with a diagnosis of congenital, cyclic or idiopathic neutropenia, to increase neutrophil counts and to reduce the incidence and duration of infection."

Please note for the first criterion: coverage cannot be considered for palliative patients.

PEGFILGRASTIM (e.g. Fulphila, Lapelga, Neulasta, Ziextenzo) special authorization criteria

"In patients with non-myeloid malignancies, receiving myelosuppresive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia."

Please note: coverage cannot be considered for palliative patients.

PLERIXAFOR (e.g. Mozobil) special authorization criteria

"For the treatment of patients with Non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM) undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy, in combination with filgrastim, when prescribed by a designated prescriber."

Coverage may be approved for a maximum of four doses (0.24mg/kg given daily) for a single mobilization attempt.

Special authorization may be granted for 12 months.