ALBERTA BLUE CROSS®

OMALIZUMAB for Asthma
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 ☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH(YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

SPECIALIST IN RESPIROLOGY OR CLINICAL IMMUNOLOGIST INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
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	Current weight (kg)	Smoking status	**Please indicate if this patient is**
☐ Severe persistent asthma ☐ Other (please specify) _____		☐ Smoker ☐ Non-smoker	☐ starting drug upon approval …… . **complete section I** ☐ new to coverage but currently maintained on drug …**complete section I and II** ☐ submitting renewal request ……..**complete section II**

Section I: Please provide 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 per cent predicted)	Date		Score #2	Date

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

a) an emergency room visit/hospitalization _____

b) physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids _____

***Please provide exact numbers. If the patient has had no exacerbations, it should be reported as 'zero (0)'.**

Previous medications utilized: Check all that apply and include name of medication, dose, duration and response.

☐ High-dose inhaled corticosteroids

☐ Long-acting beta-2 agonists

☐ Oral corticosteroids

Please check if the following applies

Chronic use (greater than 50 per cent of the year) of oral corticosteroids prior to initiation of omalizumab? Yes ☐ No ☐

Section II: Complete the following 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**

a) an emergency room visit/hospitalization _____

b) physician visits resulting in oral corticosteroids or an increased dose of oral corticosteroids _____

***Please provide exact numbers. If the patient has had no exacerbations, it should be reported as 'zero (0)'**

Please check if the following applies:

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

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

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