

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(YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER		<input type="checkbox"/> Alberta Blue Cross	<input type="checkbox"/> Alberta Human Services
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER
			<input type="checkbox"/> Other	

SPECIALIST IN RESPIROLOGY OR CLINICAL IMMUNOLOGIST INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO
CITY, PROVINCE			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C
POSTAL CODE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other
			REGISTRATION NUMBER	
			PHONE	FAX
FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED				

Please provide the following information for ALL requests

Diagnosis <input type="checkbox"/> Severe persistent asthma <input type="checkbox"/> Other (please specify) _____	Current weight (kg) _____	Smoking status <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	Please indicate if this patient is <input type="checkbox"/> starting drug upon approval complete section I <input type="checkbox"/> new to coverage but currently maintained on drug ... complete section I and II <input type="checkbox"/> submitting renewal request complete section II
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Section I: Please provide pre-treatment information for NEW requests for treatment-naïve and treatment-experienced patients

Total serum human immunoglobulin (IgE) (IU/ml)	Date	AQLQ – Juniper score	Date
<input type="checkbox"/> Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing	Date	ACQ-5 scores	Score #1
FEV1 (pre-bronchodilator per cent predicted)	Date		Score #2

*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
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*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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and 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 purposes 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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