ALBERTA BLUE CROSS®

EPLERENONE / IVABRADINE / SACUBITRIL+VALSARTAN 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**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services
				☐ Other _____
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

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

Drug requested

☐ **Eplerenone (e.g. Inspra) → complete section I only**

☐ **Ivabradine (e.g. Lancora) → complete sections I, II and III**

☐ **Sacubitril+Valsartan (e.g. Entresto) → complete sections I, II and IV**

Note: - For coverage of Ivabradine or Sacubitril+Valsartan, the drug must be initiated by a specialist in cardiology or internal medicine.

- If the patient is already on the requested drug, information provided should reflect the patient's status prior to starting the drug.

Section I. For ALL requests, please specify the following:

a) Diagnosis

☐ Heart failure (HF) → chronic? ☐ Yes ☐ No

☐ Other (specify) _____

b) Left ventricular ejection fraction (LVEF) (%) _____

c) New York Heart Association (NYHA) class _____

Section II. For Ivabradine or Sacubitril+Valsartan requests, please provide the following information

d) Drugs utilized ***prior to the requested drug***: Please check ALL that apply and indicate the name of the drugs utilized and response to each. If there is a contraindication to a particular therapy, elaborate as to its nature.

☐ Angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor antagonist (ARB) _____

☐ Beta-blocker _____

☐ Aldosterone antagonist _____

☐ Other recommended therapies _____

e) Are the HF symptoms present/active despite at least FOUR weeks of treatment with a stable dose of an ACEI or an ARB in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)?

☐ Yes ☐ No, explain _____

f) If the patient is already on the requested drug, please indicate treatment start date _____

Section III. For Ivabradine requests, please provide the following information:

g) Resting Heart Rate _____ bpm (on average using either an ECG on at least three separate visits or by continuous monitoring)

h) In sinus rhythm? ☐ Yes ☐ No

i) Number of hospitalizations due to HF in the last 12 months _____

Section IV. For Sacubitril+Valsartan requests, please provide the following information:

j) Plasma B-type natriuretic peptide (BNP) level (pg/mL) _____ and date _____; **OR**

N-terminal prohormone B-type natriuretic peptide (NT-proBNP) level (pg/mL) _____ and date _____

k) Has been hospitalized for HF within the past 12 months prior to the BNP or NT-proBNP testing date? ☐ Yes ☐ No

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®

EPLERENONE/SACUBITRIL+VALSARTAN SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

EPLERENONE (e.g. Inspra) special authorization criteria

"For persons suffering from New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction with ejection fraction less than or equal to 35 per cent as a complement to standard therapy."

Special authorization will be granted for 12 months.

This product is eligible for auto-renewal.

IVABRADINE (e.g. Lancora) special authorization criteria

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (less than or equal to 35%)

And

2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of optimal treatment with

- a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)

- in combination with a beta-blocker and, if tolerated, a mineralcorticoid receptor antagonist (MRA)

And

3) Who are in sinus rhythm with a resting heart rate greater than or equal to 77 beats per minute (bpm) on average using either an ECG on at least three separate visits or by continuous monitoring

And

4) Who had at least one hospitalization due to HF in the last year

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

SACUBITRIL + VALSARTAN (e.g. Entresto) special authorization criteria

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (< 40%)

And

2) New York Heart Association (NYHA) class II or Ill HF symptoms despite at least FOUR weeks of treatment with

- a stable dose of an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)

- in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)

And

3) Who have Plasma B-type natriuretic peptide (BNP) >= 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) >= 600 pg/mL; or

- if the patient has been hospitalized for HF within the past 12 months and has plasma BNP >= 100 pg/mL or NT-proBNP >= 400 pg/mL levels

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months.

This product is eligible for auto-renewal.

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