ALBERTA BLUE CROSS®

OMALIZUMAB for Chronic Idiopathic Urticaria 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

PATIENT LAST NAME	FIRST NAME	INITIAL	COVERAGE TYPE
			☐ 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 ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Moderate to severe Chronic Idiopathic Urticaria (CIU)

☐ Other (specify) _____

Please indicate if this patient is

☐ Starting drug upon approval …….. **complete section I**

☐ New to coverage but currently maintained on drug … **complete section I and II**

☐ Renewal request …….. **complete section II**

Section I: Please provide <u>pre-treatment</u> information for all INITIAL requests

i) Has the patient had a therapeutic trial with H1 antihistamines?

☐ Yes → a) Specify H1 antihistamines used _____

b) Specify response to therapy ☐ Failure ☐ Intolerance ☐ Other (specify) _____

☐ No → Provide reason _____

ii) Were oral therapies other than H1 antihistamines tried?

☐ Yes → Specify drugs utilized, including dose, duration and patient's response _____

_____

☐ No → Provide reason _____

iii) Baseline (pre-treatment) measure of disease severity

Urticaria Activity Score over seven days (UAS7) _____ Date _____

iv) Is the patient currently on therapy with omalizumab? ☐ Yes → Indicate start date of therapy _____ ☐ No

Section II: Complete for ADDITIONAL 24-WEEK TREATMENT COURSE requests and TREATMENT RE-INITIATION requests

i) Measure of disease severity at the end of the previous 24-week treatment course of omalizumab

UAS7 score _____ Date _____

ii) If the patient's UAS7 score recorded above for i) is zero (0), was this complete symptom control maintained for at least 12 consecutive weeks? ☐ Yes ☐ No ☐ Not applicable (patient's UAS7 at the end of treatment was not zero)

iii) Has omalizumab been discontinued due to temporary symptom control? ☐ Yes → Answer a) and b) below ☐ No

a) Provide the date of discontinuation of previous course of omalizumab _____

b) Provide the current measure of disease severity: UAS7 score _____ Date _____

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

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.

ALBERTA BLUE CROSS®

OMALIZUMAB
for Chronic Idiopathic Urticaria
SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

For the treatment of adults and adolescents (12 years of age and above) with moderate to severe chronic idiopathic urticaria (CIU), defined as having a baseline Urticaria Activity Score over seven days (UAS7) of greater than or equal to 16, who remain symptomatic (presence of hives and/or associated itching) despite optimum management with available oral therapies. Oral therapies should include a therapeutic trial with H_1 antihistamines, unless contraindicated or not tolerated.

For coverage, the drug must be initiated and monitored by a Specialist in Dermatology, Clinical Immunology or Allergy.

Coverage may be approved for a period of 24 weeks at a maximum dose of 300 mg every four weeks.
Patients will be limited to receiving a one-month supply of omalizumab per prescription at their pharmacy.
Patients are limited to receiving one biologic agent at a time regardless of the condition for which it is being prescribed.

Continued coverage of a further 24-week treatment period may be considered if the patient has experienced:
- complete symptom control (i.e. UAS7 of 0) for less than 12 consecutive weeks; OR
- partial symptom control, with a reduction in baseline UAS7 of greater than or equal to 9.5 points.

Treatment cessation should be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24-week treatment period.

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation should be considered should CIU symptoms reappear.