ALBERTA BLUE CROSS®

BENRALIZUMAB / MEPOLIZUMAB 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
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER	

STREET ADDRESS	CITY	PROV.	POSTAL CODE

COVERAGE TYPE

☐ Alberta Blue Cross
☐ Alberta Human Services
☐ Other _____

ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY, PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other

REGISTRATION NUMBER

PHONE | FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Requested drug ☐ Fasenra ☐ Nucala

Dosage and frequency

Diagnosis
☐ Severe Eosinophilic Asthma
☐ Other (please 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**
☐ Renewing coverage ……..**complete section II**

Section I: Please provide pre-treatment information for NEW requests for treatment-naive and treatment-experienced patients

1) Blood eosinophil count _____ (cells/mcL) **Date** _____

2) Number* of clinically significant exacerbations of asthma within the 12-month period prior to starting the requested drug
(defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized) _____

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

3) Asthma Control Questionnaire (ACQ-5) score _____ **Date** _____

4) Current medications: Check all that apply and include name of medication, dose, duration and response

☐ High-dose inhaled corticosteroids _____

☐ Oral corticosteroids (OCS) _____
→ Patient requires daily maintenance OCS prior to initiation of requested drug? ☐ Yes ☐ No

☐ Other asthma controllers (e.g. long-acting beta-2 agonist, please specify) _____

Section II: Complete the following for all RENEWAL requests and for INITIAL requests for treatment-experienced patients

1) Number* of clinically significant asthma exacerbations within the previous 12-month period while on the requested drug
(defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department visit or was hospitalized) _____

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

2) Current Asthma Control Questionnaire (ACQ-5) score _____ **Date** _____

3) Check if the following applies to the patient in the previous 12-month period while on the requested drug

☐ A decrease in the daily maintenance OCS dose from pre-treatment baseline
☐ The reduction in the daily maintenance OCS dose achieved after the first 12 months of therapy has at least been maintained

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	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 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.