ALBERTA BLUE CROSS®

DARIFENACIN HYDROBROMIDE/ FESOTERODINE FUMARATE/ MIRABEGRON/TROSPIUM CHLORIDE 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**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ 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 REGISTRATION NO. ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of darifenacin hydrobromide, fesoterodine fumarate, and trospium chloride

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

For patients who have failed on or are intolerant to solifenacin or tolterodine LA.

Special authorization may be granted for 24 months.

Criteria for Coverage of mirabegron

FIRST-LINE DRUG PRODUCT(S): SOLIFENACIN OR TOLTERODINE LA

For patients who have failed on or are intolerant to solifenacin or tolterodine LA.

Special authorization may be granted for 24 months.

Coverage cannot be provided for mirabegron when this medication is intended for use in combination with other overactive bladder agents.

Please indicate which drug is requested

☐ darifenacin hydrobromide (e.g. Enablex) ☐ fesoterodine fumarate (e.g. Toviaz) ☐ trospium chloride (e.g. Trosec)

☐ mirabegron (e.g. Myrbetriq) → Note that if the patient has a previous authorization for another overactive bladder agent, the previous authorization will be discontinued to facilitate the authorization of mirabegron

Please indicate if **solifenacin or tolterodine LA** was tried

☐ Yes

☐ No, specify reason _____

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 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.