ALBERTA BLUE CROSS®

BUROSUMAB
SPECIAL AUTHORIZATION REQUEST FORM

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

Please complete all required sections to allow your request to be processed.

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
ADDRESS			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
CITY, PROVINCE	PHONE		FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Please provide the following information for ALL requests

Diagnosis

☐ X-linked hypophosphatemia (XLH)

☐ Other (specify)

_____

Please indicate if this patient is

☐ starting drug upon approval ……....complete section I

☐ new to coverage but currently maintained on drug …..complete sections I & II

☐ submitting renewal request …… complete section II

Dose and frequency requested

Section I: INITIAL requests for treatment naïve and treatment experienced patients

Please indicate which of the following apply to this patient at treatment initiation (check yes or no for 1-5 below)

1) At least one year of age and epiphyseal closure has/had not yet occurred	☐ Yes	☐ No
2) Fasting hypophosphatemia	☐ Yes	☐ No
3) Normal renal function (defined as fasting serum creatinine below the age-adjusted upper limit of normal)	☐ Yes	☐ No
4) Radiographic evidence of rickets → please provide rickets severity score (RSS) total score _____ and date _____	☐ Yes	☐ No
5) Confirmed phosphate-regulating endopeptidase homolog, X-linked (PHEX) gene variant in either the patient or in a directly related family member with appropriate X-linked inheritance → please provide a copy of the genetic test report	☐ Yes	☐ No

Section II: RENEWAL requests and INITIAL requests for treatment experienced patients

Please indicate if the following currently applies to the patient (check yes or no)

1) Epiphyseal closure has occurred	☐ Yes	☐ No

→ If no, provide current RSS total score _____ and date _____

→ If yes, indicate whether any of the following have occurred by checking yes or no for a-c below

a) Hyperparathyroidism	☐ Yes	☐ No
b) Nephrocalcinosis	☐ Yes	☐ No
c) Evidence of fracture or pseudofracture based on radiographic assessment	☐ Yes	☐ No

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.

BUROSUMAB
SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

BUROSUMAB (e.g. Crysvita) special authorization criteria
"For the treatment of X-linked hypophosphatemia (XLH) in patients who meet ALL of the following criteria: Treatment is initiated in pediatric patients who are at least one year of age and in whom epiphyseal closure has not yet occurred, and who have: • fasting hypophosphatemia, and • normal renal function (defined as fasting serum creatinine below the age-adjusted upper limit of normal), and • radiographic evidence of rickets with a rickets severity score (RSS) total score of two or greater, and • a confirmed phosphate-regulating endopeptidase homolog, X-linked (PHEX) gene variant in either the patient or in a directly related family member with appropriate X-linked inheritance. For coverage, this drug must be prescribed by a Specialist in Medical Genetics, Endocrinology, Nephrology, Orthopedic Surgery or Rheumatology. • Coverage may be approved for a starting dose of 0.8 mg/kg every 2 weeks, then increased up to a maximum dose of 2 mg/kg (up to a maximum of 90 mg) every two weeks. Special authorization may be granted for 12 months. Patients will be limited to receiving a 4-week supply of burosumab per prescription at their pharmacy. For continued coverage beyond 12 months, the patient must meet the following criteria: 1) In pediatric patients in whom epiphyseal closure has not yet occurred: • for the first renewal, improvement of 12-month RSS total score when compared to pre-treatment baseline, and • for subsequent renewals, the RSS total score achieved after the first 12 months of therapy is at least maintained. 2) In adolescent or adult patients who initiated burosumab based on the criteria for pediatric patients, coverage may be renewed unless any of the following occur: • hyperparathyroidism, or • nephrocalcinosis, or • evidence of fracture or pseudofracture based on radiographic assessment."

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