ALBERTA BLUE CROSS®

DAPAGLIFLOZIN
For Heart Failure
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 ☐ Alberta Human Services ☐ Other ________________________
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER				
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	

Criteria for Coverage of Dapagliflozin (e.g. Forxiga) for Heart Failure

" FIRST-LINE DRUG PRODUCT(S): Note two out of the three following drug classes are required.
- ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACEI) OR ANGIOTENSIN II RECEPTOR ANTAGONIST (ARB) AND/OR
- BETA-BLOCKER AND/OR
- MINERALOCORTICOID RECEPTOR ANTAGONIST (MRA)

"As add-on therapy for the treatment of heart failure with reduced ejection fraction (HFrEF) patients with the following criteria:
1) Reduced left ventricular ejection fraction (LVEF) (less than or equal to 40%)
And
2) New York Heart Association (NYHA) class II or III HF symptoms
And
3) When used as adjunctive therapy to standard therapy including:
- a stable dose of an angiotensin converting enzyme inhibitor (ACEI) OR angiotensin II receptor antagonist (ARB)
And
- a beta-blocker
And,
-if tolerated, a mineralocorticoid receptor antagonist (MRA)

Special authorization may be granted for 24 months."

Note: Dapagliflozin (e.g. Forxiga) is also eligible via special authorization/step therapy for the treatment of Type 2 diabetes. Please refer to the Alberta Drug Benefit List for the complete criteria and to the DPP-4/SGLT2 Inhibitors/ GLP-1 Receptor Agonists Special Authorization Request Form (ABC 60012).

Please provide the following information for ALL requests for the treatment of Heart Failure

1) Please indicate if an **angiotensin-converting enzyme inhibitor (ACEI)** or **angiotensin II receptor antagonist (ARB)** was tried

☐ Yes, specify drug name ________________________ ☐ No, specify reason ________________________

2) Please indicate if a **beta-blocker** was tried

☐ Yes, specify drug name ________________________ ☐ No, specify reason ________________________

3) Please indicate if a **mineralocorticoid receptor antagonist** was tried

☐ Yes, specify drug name ________________________ ☐ 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.

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