ALBERTA BLUE CROSS®

LUSPATERCEPT
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

☐ Treatment of red blood cell (RBC) transfusion-dependent anemia associated with
- ☐ beta-thalassemia → **Complete Section I ONLY**
- ☐ very low- to intermediate-risk MDS in patients with ring sideroblasts→ **Complete Section II ONLY**

☐ Other, specify ______

Weight (kg) ______

For patients new to coverage and already on the requested drug, specify start date (YYYY-MM-DD) ______

Section I. Luspatercept for BETA-THALASSEMIA ASSOCIATED ANEMIA requests

A. INITIAL requests for treatment-naïve and treatment-experienced BETA-THALASSEMIA patients

Please indicate the patient's **pre-treatment** transfusion burden over the 24 weeks prior to treatment initiation _______ (RBC units/8 weeks)

Is the patient receiving regular transfusions, defined as the following in the 24 weeks prior to treatment initiation?

Receiving 6 to 20 RBC units	☐ Yes	☐ No
No transfusion-free period greater than 35 days	☐ Yes	☐ No

B. RENEWAL requests and INITIAL requests for treatment-experienced BETA-THALASSEMIA patients

Please indicate the patient's **current** transfusion burden over the last approval period _______ (RBC units/8 weeks)

Section II. Luspatercept for MYELODYSPLASTIC SYNDROME (MDS) ASSOCIATED ANEMIA requests

A. INITIAL requests for treatment-naïve and treatment-experienced MDS patients

Has the patient used erythropoietin-based therapy?

☐ **Yes,** please indicate response ______

☐ **No**, please indicate why this therapy is not suitable ______

B. RENEWAL requests and INITIAL requests for treatment-experienced MDS patients

Has the patient been RBC transfusion independent over a minimum of 16 consecutive weeks within the previous 24 weeks of treatment? ☐ Yes ☐ No

Additional information related 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.

®*The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan. ®† Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association. ABC 60106 (2023/02)