ALBERTA BLUE CROSS®

DARBEPOETIN/EPOETIN 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 _____
DATE OF BIRTH (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 ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested (check one box) ☐ **Darbepoetin** ☐ **Epoetin**

PLEASE COMPLETE ALL APPLICABLE SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

ANEMIA OF CHRONIC RENAL FAILURE (does not apply to epoetin 30,000 or 40,000 IU/syringe strengths)

☐ anemia of chronic renal failure

☐ other (please specify) _____

This section applies only to patients who received a renal transplant
Please indicate if the renal transplant is failing or has failed
☐ Yes ☐ No

NEW patients
a) Provide pre-treatment hemoglobin level (g/L) _____

b) Is the hemoglobin level falling? ☐ Yes ☐ No

Patients currently on darbepoetin or epoetin
Provide current hemoglobin level (g/L)

Please provide the current iron status: Transferrin saturation is >20% ☐ Yes ☐ No

CHEMOTHERAPY-INDUCED ANEMIA (includes epoetin 30,000 and 40,000 IU/syringe strengths)

Please specify the type of cancer _____

☐ other (please specify) _____

For the treatment of anemia
Please indicate if the anemia is chemotherapy-induced
☐ Yes ☐ No, please specify _____

Please provide the patient's hemoglobin level (g/L)

Please specify the reason why blood transfusions are not an option
☐ Transfusion reactions in the past ☐ Difficulty cross-matching the patient
☐ Iron overload ☐ Other, please specify: _____

ANEMIA IN AZT-TREATED/HIV INFECTED PATIENTS (does not apply to darbepoetin or epoetin 30,000 or 40,000 IU/syringe strengths)

☐ anemia in AZT-treated/HIV infected patients

☐ other, please specify _____

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.

ALBERTA BLUE CROSS®

DARBEPOETIN/EPOETIN SPECIAL AUTHORIZATION CRITERIA

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

Criteria for coverage

DARBEPOETIN

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for 12 months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 300 mcg per month."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25 per cent. Special authorization will be granted for 12 months."

In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.

In order to comply with the second criterion, if the patient has iron overload, the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation along with results of liver function tests if applicable.

For the second criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.

The following product(s) are eligible for auto-renewal for the indication of the treatment of anemia of chronic renal failure.

EPOETIN (ALL strengths except 30,000 and 40,000 IU/syringe)

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<95 g/L and falling). Patients must be iron replete prior to initiation of therapy as indicated by transferrin saturation >20%. Special authorization will be granted for 12 months.

According to current clinical practice, hemoglobin levels should be maintained between 95 g/L to 110 g/L and the dose should be held or reduced when hemoglobin is greater than or equal to 115 g/L. Doses should not exceed 60,000 units per month."

"For the treatment of anemia in AZT-treated/HIV infected patients. Special authorization will be granted for twelve months."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25%. Special authorization will be granted for 12 months."

In order to comply with the first criterion, information must be provided regarding the patient's hemoglobin and transferrin saturation.

In order to comply with the third criterion: if the patient has iron overload, the prescriber must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the third criterion, renewal requests may be considered if the patient's hemoglobin is < 110 g/L while on therapy.

The following product(s) are eligible for auto-renewal for the indication of treatment of anemia of chronic renal failure.

EPOETIN 30,000 and 40,000 IU/syringe strengths

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose should be reduced by about 25 per cent. Patients may be granted a maximum allowable dose of 40,000 IU per week. Special authorization will be granted for 12 months."

In order to comply with this criterion, if the patient has iron overload, the prescriber must state this in the request, or alternatively, information is required regarding the patient's transferrin saturation along with the results of liver function tests, if applicable.

Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on therapy.

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