

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		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> 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		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Indicate which drug is requested		
For the treatment of Type 2 diabetes	Criteria for coverage*	Complete sections
<input type="checkbox"/> CANAgliflozin (e.g. Invokana) <input type="checkbox"/> SAXAgliptin + metformin (e.g. Komboglyze) <input type="checkbox"/> LINAgliptin (e.g. Trajenta) <input type="checkbox"/> SEMAglutide (e.g. Ozempic) <input type="checkbox"/> LINAgliptin + metformin (e.g. Jentadueto) <input type="checkbox"/> SITAgliptin (e.g. Januvia) <input type="checkbox"/> SAXAgliptin (e.g. Onglyza) <input type="checkbox"/> SITAgliptin + metformin (e.g. Janumet, Janumet XR)	First-line drug products: metformin Second-line drug products: sulfonylureas And where insulin is not an option	Sections 1 and 2
<input type="checkbox"/> LIXisenatide (e.g. Adlyxine)	First-line drug products: metformin Second-line drug products: sulfonylureas And insulin	Sections 1 and 2
For the treatment of Type 2 diabetes OR Type 2 diabetes and established CV diseases as defined in the criteria for coverage	Criteria for coverage*	Complete sections
<input type="checkbox"/> EMPAgliflozin (e.g. Jardiance) <input type="checkbox"/> EMPAgliflozin + metformin (e.g. Synjardy)	*See page 2 for complete criteria	Sections 1 and/or 2 (as applicable)

<b>Section 1</b>	Please indicate if <b>metformin</b> was tried for <b>at least 6 months</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, specify reason _____
<b>Section 2</b>	Please indicate if a <b>sulfonylurea</b> was tried <input type="checkbox"/> Yes <input type="checkbox"/> No, specify reason _____  Please indicate if <b>insulin</b> was tried <input type="checkbox"/> Yes <input type="checkbox"/> No, indicate why insulin is not an option for this patient <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Manual dexterity concerns <input type="checkbox"/> Needle phobia <input type="checkbox"/> Visual impairment <input type="checkbox"/> Other, specify _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to ▪ <b>Alberta Blue Cross, Clinical Drug Services</b> <b>10009-108 Street NW, Edmonton, Alberta T5J 3C5</b> ▪ <b>FAX: 780-498-8384</b> in Edmonton • <b>1-877-828-4106</b> toll free all other areas
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**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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## Criteria for coverage

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

### **CANAgliptin (e.g. Invokana), LINAgliptin (e.g. Trajenta), LINAgliptin + metformin (e.g. Jentadueto), LIXIsenatide (e.g. Adlyxine), SAXAgliptin (e.g. Onglyza), SAXAgliptin + metformin (e.g. Komboglyze), SEMAglutide (e.g. Ozempic), SITAgliptin (e.g. Januvia) and SITAgliptin + metformin (e.g. Janumet, Janumet XR) special authorization criteria**

FIRST-LINE DRUG PRODUCTS: METFORMIN  
SECOND-LINE DRUG PRODUCTS: SULFONYLUREAS  
AND WHERE INSULIN IS NOT AN OPTION

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on

- a sufficient trial (such as a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

### **EMPAgliflozin (e.g. Jardiance) and EMPAgliflozin + metformin (e.g. Synjardy) special authorization criteria**

FIRST-LINE DRUG PRODUCTS: METFORMIN

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on

- a sufficient trial (such as a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- for whom insulin is not an option.

Or, for whom these products are contraindicated.

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes and established cardiovascular diseases who have an inadequate glycemic control, if the following criteria are met:

- a sufficient trial (such as a minimum of 6 months) of metformin, AND
- established cardiovascular disease\* as defined in the EMPA-REG OUTCOME trial.

\* Established cardiovascular disease is defined on the basis of 1 of the following:

- 1) History of myocardial infarction.
- 2) Multi-vessel coronary artery disease in 2 or more major coronary arteries (irrespective of revascularization status).
- 3) Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress or discharged from hospital with a documented diagnosis of unstable angina within the last 12 months.
- 4) Last episode of unstable angina greater than 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease.
- 5) History of ischemic or hemorrhagic stroke.
- 6) Occlusive peripheral artery disease.

Special authorization may be granted for 24 months.

### **LIXIsenatide (e.g. Adlyxine) special authorization criteria**

FIRST-LINE DRUG PRODUCTS: METFORMIN  
SECOND-LINE DRUG PRODUCTS: SULFONYLUREAS  
AND INSULIN

"As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on

- a sufficient trial (such as a minimum of 6 months) of metformin, AND
- a sulfonylurea, AND
- insulin.

Or, for whom these products are contraindicated.

Special authorization may be granted for 24 months.

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