

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	
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				
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER	
PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
ADDRESS			REGISTRATION NUMBER		
			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other		
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
<b>Drug requested</b> <input type="checkbox"/> Eplerenone (e.g. Inspra) → complete section I only <input type="checkbox"/> Ivabradine (e.g. Lancora) → complete sections I, II and III <input type="checkbox"/> Sacubitril+Valsartan (e.g. Entresto) → complete sections I, II and IV					
<b>Note:</b> - For coverage of Ivabradine or Sacubitril+Valsartan, the drug must be initiated by a specialist in cardiology or internal medicine. - If the patient is already on the requested drug, information provided should reflect the patient's status prior to starting the drug.					
<b>Section I. For ALL requests, please specify the following:</b>					
a) Diagnosis			b) Left ventricular ejection fraction (LVEF) (%) _____		
<input type="checkbox"/> Heart failure (HF) → chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (specify) _____			c) New York Heart Association (NYHA) class _____		
<b>Section II. For Ivabradine or Sacubitril+Valsartan requests, please provide the following information</b>					
d) Drugs utilized <b>prior to the requested drug</b> : Please check ALL that apply and indicate the name of the drugs utilized and response to each. If there is a contraindication to a particular therapy, elaborate as to its nature.					
<input type="checkbox"/> Angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor antagonist (ARB) _____ <input type="checkbox"/> Beta-blocker _____ <input type="checkbox"/> Aldosterone antagonist _____ <input type="checkbox"/> Other recommended therapies _____					
e) Are the HF symptoms present/active despite at least FOUR weeks of treatment with a stable dose of an ACEI or an ARB in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain _____					
f) If the patient is already on the requested drug, please indicate treatment start date _____					
<b>Section III. For Ivabradine requests, please provide the following information:</b>					
g) Resting Heart Rate _____ bpm (on average using either an ECG on at least three separate visits or by continuous monitoring)					
h) In sinus rhythm? <input type="checkbox"/> Yes <input type="checkbox"/> No			i) Number of hospitalizations due to HF in the last 12 months _____		
<b>Section IV. For Sacubitril+Valsartan requests, please provide the following information:</b>					
j) Plasma B-type natriuretic peptide (BNP) level (pg/mL) _____ and date _____; <b>OR</b> N-terminal prohormone B-type natriuretic peptide (NT-proBNP) level (pg/mL) _____ and date _____					
k) Has been hospitalized for HF within the past 12 months prior to the BNP or NT-proBNP testing date? <input type="checkbox"/> Yes <input type="checkbox"/> No					
PRESCRIBER'S SIGNATURE		DATE (YYYY-MM-DD)		Please forward this request to <b>Alberta Blue Cross, Clinical Drug Services</b> 10009 108 Street NW, Edmonton, Alberta T5J 3C5 FAX <b>780-498-8384</b> in Edmonton • <b>1-877-828-4106</b> 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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**Criteria for coverage**

**EPLERENONE (e.g. Inspra) special authorization criteria**

"For persons suffering from New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction with ejection fraction less than or equal to 35 per cent as a complement to standard therapy."

Special authorization will be granted for 12 months.

This product is eligible for auto-renewal.

**IVABRADINE (e.g. Lancora) special authorization criteria**

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (less than or equal to 35%)

And

2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of optimal treatment with  
- a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)  
- in combination with a beta-blocker and, if tolerated, a mineralcorticoid receptor antagonist (MRA)

And

3) Who are in sinus rhythm with a resting heart rate greater than or equal to 77 beats per minute (bpm) on average using either an ECG on at least three separate visits or by continuous monitoring

And

4) Who had at least one hospitalization due to HF in the last year

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months."

This product is eligible for auto-renewal.

**SACUBITRIL + VALSARTAN (e.g. Entresto) special authorization criteria**

For the treatment of heart failure (HF) in patients with the following criteria:

1) Reduced left ventricular ejection fraction (LVEF) (< 40%)

And

2) New York Heart Association (NYHA) class II or III HF symptoms despite at least FOUR weeks of treatment with  
- a stable dose of an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB)  
- in combination with a beta-blocker and other recommended therapies, including an aldosterone antagonist (if tolerable)

And

3) Who have Plasma B-type natriuretic peptide (BNP)  $\geq$  150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP)  $\geq$  600 pg/mL; or

- if the patient has been hospitalized for HF within the past 12 months and has plasma BNP  $\geq$  100 pg/mL or NT-proBNP  $\geq$  400 pg/mL levels

For coverage, this drug must be initiated by a specialist in cardiology or internal medicine, and the initial request must be completed by the specialist.

Special authorization may be granted for six months.

This product is eligible for auto-renewal.