ALBERTA BLUE CROSS®

ALIROCUMAB / EVOLOCUMAB for HeFH
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
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 ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

1) Drug requested ☐ Praluent ☐ Repatha

2) Dosage and frequency

3) Diagnosis

☐ **Definite or Probable** diagnosis of heterozygous familial hypercholesterolemia (HeFH)

→Was the diagnosis confirmed using the Simon Broome or Dutch Lipid Network criteria, or genetic testing? ☐Yes ☐No

☐ Other (specify) _____

Please provide the following information for INITIAL requests for treatment-naive and treatment-experienced patients

1) Pre-treatment Low Density Lipoprotein-Cholesterol (LDL-C) _____ (mmol/L) Date _____

Note *Pre-treatment refers to the LDL-C level taken prior to initiation of the requested drug, rather than the untreated baseline LDL-C level.*

2) Previous therapy *(check the applicable box)*

☐ Adherence to **high dose statin** (e.g. atorvastatin 80 mg or rosuvastatin 40 mg) in combination with **ezetimibe** for at least three months

→Specify statin utilized _____ **Dose** _____

OR

☐ Adherence to **ezetimibe** for at least three months *[please confirm if patient meets a) or b) below by checking the applicable box]*

→ **a)** ☐ **Statins are contraindicated** (specify) _____

→ **b)** ☐ **Patient was unable to tolerate high dose statin** *[please complete i) to v) below]*

i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose *[specify 2 statins utilized including dose and check ALL that apply for ii) to v) for each statin below]*

☐ **Statin #1** _____ **Dose** _____ ☐ **Statin #2** _____ **Dose** _____

ii)	Dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality [creatine kinase (CK) > five times the upper limit of normal (ULN)] resolution rather than discontinuation of statin altogether	☐ Statin #1	☐ Statin #2
iii)	Intolerable symptoms (myopathy) or abnormal biomarkers (CK > five times the ULN) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate	☐ Statin #1	☐ Statin #2
iv)	Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out	☐ Statin #1	☐ Statin #2
v)	Patient developed confirmed and documented rhabdomyolysis	☐ Statin #1	☐ Statin #2

3) Despite the above previous therapy, is the patient unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention)? ☐Yes ☐No

4) If the patient is currently on the requested drug, please indicate start date (YYYY-MM-DD) _____

Please provide the following information for RENEWAL requests and for INITIAL requests for treatment-experienced patients

1) Is the patient adherent to therapy? ☐Yes ☐No

2) Current LDL-C _____ (mmol/L) Date _____

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 collected by this form is collected 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 purpose 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.