ALBERTA BLUE CROSS®

BENRALIZUMAB / DUPILUMAB/ MEPOLIZUMAB For Asthma
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 ☐ Alberta Human Services ☐ 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	☐ 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

Requested drug ☐ Dupixent ☐ Fasenra ☐ Nucala

Dosage and Frequency

Diagnosis
- ☐ Severe Eosinophilic Asthma
- ☐ Type 2 asthma (pediatric patients aged 6-11 only)
- ☐ Other (please specify) ____________________

Please indicate if this patient is
- ☐ Starting drug upon approval .... **complete section I**
- ☐ New to coverage but currently maintained on drug .... **complete section I and II**
- ☐ Renewing coverage .... **complete section II**

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

Section I: Please provide pre-treatment information for NEW requests for treatment-naïve and treatment-experienced patients

1) **Blood eosinophil count** __________(cells/mcL) **Date** __________

2) **Number* of clinically significant exacerbations of asthma within the 12-month period prior to starting the requested drug** (defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized) ____________________
***Please provide an exact number. If the patient has had no exacerbations it should be reported as 'zero (0)'.**

3) **Pre-treatment Asthma Control Questionnaire (ACQ-5) score** __________ **Date** __________

4) **Previous medications utilized:** Check all that apply and include name of medication, dose, duration and response
- ☐ Inhaled corticosteroids ____________________ → Specify dose ☐ High-dose ☐ Medium-dose
- ☐ For adults and adolescents aged 12 and older, oral corticosteroids (OCS) ____________________
  - → Patient requires daily maintenance OCS prior to initiation of requested drug? ☐ Yes ☐ No
- ☐ Other asthma controllers (e.g. long-acting beta-2 agonist, please specify) ____________________

Section II: Complete the following for all RENEWAL requests and INITIAL requests for treatment experienced patients

1) **Number* of clinically significant asthma exacerbations within the previous 12-month period while on the requested drug** (defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized) ____________________
***Please provide an exact number. If the patient has had no exacerbations it should be reported as 'zero (0)'.**

2) **Current Asthma Control Questionnaire (ACQ-5) score** __________ **Date** __________

3) **For patients requiring daily maintenance OCS prior to initiation of requested drug ONLY, check if the following applies:**
- ☐ A decrease in the daily maintenance OCS dose from pre-treatment baseline **in the first 12 months of treatment**
- ☐ The reduction in the daily maintenance OCS dose achieved **after the first 12 months of treatment** has at least been maintained

Additional information relating to request (if a switch to a different drug is requested, please indicate the reason for switch):

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.

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