ALBERTA BLUE CROSS®

# BENRALIZUMAB / DUPILUMAB / MEPOLIZUMAB / TEZEPELUMAB For Asthma
# 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 |
|---|---|---|---|---|
| LAST NAME | FIRST NAME | | INITIAL | ☐ Alberta Blue Cross<br>☐ Alberta Human Services<br>☐ 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<br>☐ CPSA ☐ ACO<br>☐ CARNA ☐ ADA+C<br>☐ ACP ☐ Other<br>REGISTRATION NUMBER |
| ADDRESS | | | |
| 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 ☐ Tezspire

**Dosage and Frequency**

**Diagnosis**

☐ Severe Asthma → ☐ Eosinophilic

☐ Type 2 asthma (dupilumab for 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) **For benralizumab, dupilumab, mepolizumab: 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<br>**Alberta Blue Cross, Clinical Drug Services**<br>**10009 108 Street NW, Edmonton, Alberta T5J 3C5**<br>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.**