ALBERTA BLUE CROSS®

ICATIBANT / LANADELUMAB FOR HAE TYPE I OR II 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
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services
				☐ Other _____
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
ADDRESS			☐ CARNA ☐ ADA+C
			☐ ACP ☐ Other
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug requested

☐ **Icatibant (e.g. Firazyr) → complete section I only**

☐ **Lanadelumab (e.g. Takhzyro) → complete section II only**

If the requested drug was prescribed in consultation with another physician who is experienced in the treatment of HAE, please provide the physician's name _____

Section I. For ICATIBANT (e.g. Firazyr) Requests

1) Intended use

☐ Treatment of acute attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients with C1-esterase inhibitor deficiency

☐ Other (specify) _____

2) Specify the type and severity of acute attacks to be treated

☐ Acute non-laryngeal attack(s) of at least moderate severity

☐ Acute laryngeal attack(s) of any severity

☐ Other (specify) _____

Section II. For LANADELUMAB (e.g. Takhzyro) Requests

1) Intended use – Initial Requests

☐ Routine prevention of attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE)

☐ Other (specify) _____

2) HAE attacks PRIOR to initiating long-term prophylactic therapy – Initial Requests (complete a) or b) as applicable)

a) For patients starting (or who originally began) long-term prophylactic therapy with lanadelumab

i. Indicate the *highest number* of HAE attacks that required the use of an acute injectable treatment *within any four-week period in the three months before starting* lanadelumab _____

AND

ii. Indicate the *total number* of HAE attacks requiring the use of an acute injectable treatment *in the three months before starting* lanadelumab _____

b) For patients transitioning (or have already transitioned) from another long-term prophylactic treatment (e.g. C1-INH) to lanadelumab

i. Indicate the *highest number* of HAE attacks that required the use of an acute injectable treatment *within any four-week period in the three months before starting* long-term prophylactic therapy _____

AND

ii. Indicate the *total number* of HAE attacks requiring the use of an acute injectable treatment *in the three months before starting* long-term prophylactic therapy _____

3) Response to therapy – Renewals and Initial Requests for patients already receiving long-term prophylactic treatment

Please indicate the number of HAE attacks requiring use of an acute injectable treatment *within the last three months* _____

4) Combination therapy – ALL Requests

Will lanadelumab be used in combination with other medications used for the long-term prophylactic treatment of angioedema? ☐ Yes ☐ No

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.

ALBERTA BLUE CROSS®

ICATIBANT / LANADELUMAB FOR HAE TYPE I OR II SPECIAL AUTHORIZATION CRITERIA

Criteria for coverage

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

ICATIBANT (e.g. Firazyr) special authorization criteria

"For the treatment of acute attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients with C1-esterase inhibitor deficiency. Icatibant is to be used for:
- acute non-laryngeal attack(s) of at least moderate severity, or
- acute laryngeal attack(s) of any severity

This medication must be prescribed by, or in consultation with, a physician experienced in the treatment of HAE.

Special authorization may be granted for 12 months.

Patients will be limited to a maximum of two doses of icatibant per prescription at their pharmacy."

This product is eligible for auto-renewal.

LANADELUMAB (e.g. Takhzyro) special authorization criteria

"For the routine prevention of attacks of confirmed Type 1 or Type 2 hereditary angioedema (HAE) in patients 12 years of age or older who have had at least three HAE attacks that required the use of an acute injectable treatment within any four-week period in the three months before initiating lanadelumab therapy.

This medication must be prescribed by, or in consultation with, a physician experienced in the treatment of HAE. A record of the baseline total of HAE attacks requiring use of an acute injectable treatment in the three months prior to initiating lanadelumab is required.

Initial coverage may be approved for 3 months. The patient must be assessed after the initial three months to determine response. Patients who have a response to initial treatment* may receive continued coverage with lanadelumab for six months, and should be assessed for continued response** every six months.

*Response to initial lanadelumab treatment is defined as:
- at least a 50% reduction in the number of HAE attacks requiring use of an acute injectable treatment compared to the three month baseline number of attacks prior to initiation of lanadelumab.

**Continued response is defined as:
- maintenance of a minimum improvement of a 50% reduction in the number of HAE attacks requiring use of an acute injectable treatment compared to the baseline number of attacks observed before initiating treatment with lanadelumab.

Coverage cannot be provided for lanadelumab when used in combination with other medications used for long-term prophylactic treatment of angioedema (e.g., C1-INH).

Coverage may be approved for a dosage of up to 300 mg every two weeks. Patients will be limited to receiving a one-month supply per prescription at their pharmacy."