ALBERTA BLUE CROSS®

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

Please provide the following information for ALL requests

Diagnosis

☐ Treatment of growth failure in pediatric patients with confirmed Severe Primary Insulin-like Growth Factor-1 Deficiency (SPIGFD)

➔ Please indicate if the patient has epiphyseal closure ☐ Yes ☐ No

☐ Other, specify ______

Combination therapy Will the requested drug be used in combination with recombinant Growth Hormone treatment?	☐ Yes	☐ No

Section I. INITIAL requests for treatment naïve and treatment experienced patients

Please indicate which of the following apply to this patient at treatment initiation (check yes or no for 1-6 below)

1. Known genetic mutation recognized as a cause of SPIGFD	☐ Yes	☐ No
2. Height standard deviation score less than or equal to -3.0	☐ Yes	☐ No
3. Basal insulin-like growth factor-1 (IGF-1) levels below the 2.5th percentile for age and gender	☐ Yes	☐ No
4. Random or stimulated Growth Hormone (GH) level of >10 ng/mL and failure to increase IGF-1 by 50 ng/mL in response to exogenous GH during an IGF-1 generation test	☐ Yes	☐ No
5. Secondary forms of IGF-1 deficiency have been excluded, such as malnutrition, hypopituitarism, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids.	☐ Yes	☐ No

Section II. INITIAL requests for treatment experienced patients and RENEWAL requests

Please indicate which of the following apply to this patient (check yes or no for 1-2 below)

1. Height velocity is 1 cm or greater per 6 months or 2 cm or greater per year	☐ Yes	☐ No
2. Bone age is 16 years or less in boys and 14 years or less in girls	☐ Yes	☐ No

Additional information related to request

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.

®*The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan. ®† Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association. ABC 60107 (2023/04)