ALBERTA BLUE CROSS®

BELIMUMAB
For Lupus Nephritis
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

Please provide the following information for ALL requests

Diagnosis
- ☐ Active lupus nephritis
- ☐ Other, 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 & II
- ☐ submitting renewal request ……..…..complete section II

Dosage and frequency requested

Section I: INITIAL requests for treatment-naïve and treatment-experienced patients

1)	Patient has class III with/without class V, or class IV with/without class V, or class V (i.e., pure class V) lupus nephritis?	☐ Yes	☐ No
2)	Will belimumab be used in combination with standard therapy*?	☐ Yes	☐ No
3)	Belimumab initiated within 60 days of starting standard induction* therapy?	☐ Yes	☐ No
	**Standard induction therapy includes products such as corticosteroids and mycophenolate or cyclophosphamide. Standard maintenance treatment may include products such as mycophenolate or azathioprine.*		
4)	Has the patient previously failed cyclophosphamide AND mycophenolate?	☐ Yes	☐ No
5)	**Pre-treatment** estimated glomerular filtration rate (eGFR) >/= 30 mL/min/1.73m2?	☐ Yes	☐ No
6)	**Pre-treatment** proteinuria level _____ g/24 hours and date _____		

Section II: RENEWAL requests and INITIAL requests for treatment-experienced patients

1)	Reduction in glucocorticoids to </= 7.5 mg/day (prednisone equivalent)?	☐ Yes	☐ No
2)	**Current** eGFR is >/= 60 mL/min/1.73m2 OR >/= 30 mL/min/1.73m2 and no worse than 20 per cent below the value before the renal flare (pre-flare value)?	☐ Yes	☐ No
3)	**Current** proteinuria level _____ g/24 hours and date _____		

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.