ALBERTA BLUE CROSS®

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

Please provide the following information for ALL requests

Diagnosis
☐ Primary hyperoxaluria type 1 (PH1)
☐ 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 and II
☐ Renewing coverage ……..……...complete section II

Dosage and Frequency

Current weight (kg)

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

Please provide the following pre-treatment information

1. Patient has a genetically confirmed diagnosis of PH1	☐ Yes	☐ No	
2. Where urinary oxalate can be measured, patient is unable to normalize urine oxalate excretion while staying compliant with standard of care therapy, including vitamin B6 for a duration of 3 to 6 months	☐ Yes	☐ No	☐ N/A

For patients with measurable urinary oxalate

3. Provide **pre-treatment** 24-hour urinary oxalate level _____(µmol/24hr), Date _____ and Reference range _____

For patients in whom urinary oxalate is not measurable (i.e., non-continent or end-stage kidney disease [ESKD] or dialysis)

4. **If non-continent,** provide **pre-treatment** spot urine oxalate:creatinine ratio _____ (mmol/mol) and Date _____

   If ESKD or dialysis, provide **pre-treatment** pre-dialysis plasma oxalate level _____ (µmol/L) and Date _____

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

1. Has the patient received a liver transplant with or without a kidney transplant	☐ Yes	☐ No

For patients with measurable urinary oxalate

2. Provide **current** 24-hour urinary oxalate level _____(µmol/24hr), Date _____ and Reference range _____

For patients in whom urinary oxalate is not measurable (i.e., non-continent or ESKD or dialysis)

3. **If non-continent,** provide **current** spot urine oxalate:creatinine ratio _____ (mmol/mol) and Date _____

   If ESKD or dialysis, provide **current** pre-dialysis plasma oxalate level _____ (µmol/L) 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.