ALBERTA BLUE CROSS®

MEPOLIZUMAB

For Chronic Rhinosinusitis with Nasal Polyps

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
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis

☐ Severe chronic rhinosinusitis with nasal polyps (CRSwNP)

☐ 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 sections I and II**

☐ Renewing coverage ……..…... **complete section II**

Dosage and Frequency

Mepolizumab will be used as add-on maintenance treatment with intranasal corticosteroids?

☐ Yes ☐ No, provide reason _____

Section I: Please provide <u>pre-treatment</u> information for NEW requests for treatment-naïve and treatment-experienced patients

1) Patient is inadequately controlled with intranasal corticosteroids and is experiencing refractory symptoms despite use of intranasal corticosteroids for 3 months at maximally tolerated doses	☐ Yes	☐ No
2) Patient has endoscopically- or computed tomography-documented bilateral nasal polyps	☐ Yes	☐ No
3) Patient has undergone at least 1 prior surgical intervention for nasal polyps or has a contraindication to surgery	☐ Yes	☐ No

4) ***Pre-treatment scores**

Sino-Nasal Outcome Test (SNOT-22) _____ and date _____ and/or

Endoscopic Nasal Polyps Score (NPS) _____ and date _____

*Requests for patients new to the requested drug, and requests for patients new to coverage but currently maintained on the requested drug, require pre-treatment scores.

5) For patients new to coverage and already on mepolizumab, specify start date (YYYY-MM-DD) _____

Section II: Complete the following for all RENEWAL requests and INITIAL requests for treatment-experienced patients

Current scores

Sino-Nasal Outcome Test (SNOT-22) _____ and date _____ and/or

Endoscopic Nasal Polyps Score (NPS) _____ and date _____

Additional information relating 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.