ALBERTA BLUE CROSS®

ICOSAPENT ETHYL
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			
STREET 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 ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED.

Coverage Criteria of Icosapent Ethyl (e.g. Vascepa)

Special authorization coverage may be provided to reduce the risk of cardiovascular events [CV] (CV death, non-fatal myocardial infarction, non-fatal stroke, coronary revascularization, or hospitalization for unstable angina) in statin-treated patients, age 45 years and older with established cardiovascular disease (secondary prevention) and elevated triglycerides (TGs), if the following criteria are met:

Patients must:

- be receiving a maximally tolerated statin dose, targeted to achieve a low-density lipoprotein cholesterol (LDL-C) < 2 mmol/L for a minimum of four weeks AND
- have a LDL-C > 1.0 mmol/L and < 2.6 mmol/L at baseline, AND
- have a fasting TG level of >= 1.7 mmol/L and < 5.6 mmol/L at baseline.

LDL-C and fasting TG levels must be measured within the preceding three months before starting treatment with icosapent ethyl.

Special authorization may be granted for 12 months.

Renewal requests may be considered for patients who continue to be maintained on a maximally tolerated statin dose.

Please provide the following information for INITIAL requests for treatment-naive and treatment-experienced patients

1) Indication for use

Does the patient have established cardiovascular disease?

☐ Yes, please provide specific diagnosis _____ ☐ No

2) Statin therapy

a) Patient is receiving a maximally tolerated statin dose, targeted to achieve a low-density lipoprotein cholesterol (LDL-C) < 2 mmol/L	☐ Yes	☐ No
b) Patient has been receiving a maximally tolerated statin dose for a minumum of four weeks	☐ Yes	☐ No
c) Icosapent ethyl will be used in combination with maximally tolerated statin dose	☐ Yes	☐ No
d) Specify the statin the patient is currently using _____		

3) Pre-treatment levels *within the preceding three months* before starting treatment with icosapent ethyl

a) LDL-C _____ (mmol/L) and Date _____

b) Fasting triglyceride (TG) _____ (mmol/L) and Date _____

4) For patients already on icosapent ethyl, provide the treatment start date (YYYY-MM-DD) _____

Please provide the following information for RENEWAL requests

Patient continues to be maintained on maximally tolerated statin dose?

☐ Yes, please specify statin _____ ☐ No

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.