EXPRESS SCRIPTS®

Clear Print

Prior Authorization Request

REBLOZYL (luspatercept)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Telephone: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

REBLOZYL (luspatercept)	☐ New request	☐ Renewal request*	
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Thalassemia

- ☐ For the treatment of red blood cell (RBC) transfusion-dependent anemia associated with beta(β)-thalassemia in an adult, AND
- ☐ The patient has been diagnosed with S/β-thalassemia or alpha (α)-thalassemia, AND
- ☐ The patient has received at least 6 RBC units in the past 24 weeks, AND
- ☐ The patient did not have a transfusion-free period 35 days or more during that 24-week period

Myelodysplastic Syndromes

- ☐ For the treatment of myelodysplastic syndromes (MDS) in an adult, AND
- ☐ The patient has very low, low, or intermediate risk according to the International Prognostic Scoring System (IPSS), AND
- ☐ The patient requires at least 2 red blood cell (RBC) units over 8 weeks, AND
- ☐ The patient has ring sideroblasts, AND
- ☐ The patient has had an inadequate response or has had a documented intolerance to, or is not suitable for, erythropoietin-based therapy

OR

- ☐ None of the above criteria applies.

Relevant additional information:

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2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax:
Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail:
Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5