Omlyclo (Omalizumab) for Asthma

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

Fax: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	**Fax Number:**
Prescriber Address:	**Phone Number:**
	Prescriber License Number (NOT Billing Number):

Patient First Name:	**PHIN:**	**MHSC:**
Patient Last Name:	**Patient's Date of Birth:**	

◯ **New Request** ◯ **Renewal Request**

Medication: Omalizumab (Omlyclo)	**Strength and Regimen:**	**Duration:**

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the EDS listing. Please provide the following details about how this patient meets the specific criteria for coverage. Manitoba Health may request additional documentation to support this EDS request.

For INITIAL Requests:

Diagnosis/Indication:

◯ Moderate to severe persistent allergic asthma

◯ Other: _____

Check all that apply:

The patient's asthma is inadequately controlled by high-dose inhaled corticosteroids (ICS), defined as:

☐ ≥500 mcg of fluticasone propionate or equivalent daily for patients 12 years of age and older, OR

☐ ≥400 mcg of fluticasone propionate or equivalent daily for patients 6 to 11 years or age.

☐ AND one or more additional asthma controller(s) (e.g., long-acting beta agonists [LABA])

Please provide the following details for the medications tried (as checked off above):

Category	Drug Name	Dose and Frequency	Duration of Trial	Response
ICS				
Controller				
Other				

☐ The patient has experienced two or more clinically significant asthma exacerbations in the past 12 months.

Provide the number of each:

___ Hospitalizations for asthma

___ Urgent visits for asthma to a physician or an emergency department

___ Courses of high-dose oral corticosteroids

Is the patient currently taking oral corticosteroids (OCS) for **maintenance treatment**?	◯ YES	◯ NO
If yes, please specify the corticosteroid **drug** and **dose** (mg/day):		
The patient has a positive skin test or in vitro reactivity to a perennial aeroallergen.	◯ YES	◯ NO
Will omalizumab be used in combination with other biologics used to treat asthma?	◯ YES	◯ NO

Last updated April 17, 2026

Omalizumab will be initiated and monitored by an allergist or respirologist with experience in managing severe asthma.	◯ YES	◯ NO
A baseline assessment (prior to initiation of omalizumab treatment) of the asthma symptom control using a validated asthma control questionnaire has been completed. **(please attach a copy).**	◯ YES	◯ NO

ACQ Score:	Date of Result:
Baseline IgE Level (units/mL):	Date of Result:
Patient's weight (kg):	Date of Result:

Additional Relevant Clinical Information:

For RENEWAL Requests:		
A copy of the current ACQ score has been attached.	◯ YES	◯ NO

Current ACQ Score:	Date of Result:

Provide the number of clinically significant asthma exacerbations in the last 12 months.

___ Hospitalizations for asthma

___ Urgent visits for asthma to a physician or an emergency department

___ Courses of high-dose oral corticosteroids

Is the patient currently taking oral corticosteroids (OCS) for **maintenance treatment**?	◯ YES	◯ NO

If yes, please specify the corticosteroid **drug** and **dose** (mg/day):

Prescriber Signature and Date:

Please check the following:

☐ I have discussed with the patient that the purpose of releasing their information to Manitoba Health, Seniors and Long-Term Care is to obtain Exception Drug Status for prescription coverage.

Date:	Prescriber Signature: