Omlyclo (Omalizumab) for Chronic Idiopathic Urticaria

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	
Strength and Regimen:	Expected Duration:	

Note: initial approval period of 24 weeks at a maximum dose of 300 g every 4 weeks.

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 chronic idiopathic urticaria (CIU)	
	Other: ______________________________	
The patient is 12 years of age or older.	YES	NO
This request for coverage is being made by a specialist in allergy, immunology or dermatology with knowledge of CIU treatment.	YES	NO
The patient remains symptomatic (presence of hives and/or associated itching) despite optimum management with available oral therapies.	YES	NO

Treatment History for CIU:

Name of Drug	*Dosing Regimen*	*Start Date*	*End Date (if applicable)*	*Outcome of Treatment*
				Ineffective Intolerance (specify): Contraindication (specify): Other (specify):
				Ineffective Intolerance (specify): Contraindication (specify): Other (specify):
				Ineffective Intolerance (specify): Contraindication (specify): Other (specify):

Please provide the baseline (prior to treatment with omalizumab) Urticaria Activity Score over 7 days (UAS7):

Baseline UAS7:	Date of result:

Additional Relevant Clinical Information:

For RENEWAL Requests:			
Current UAS7:	Date of result:		
Has the patient achieved complete symptom control for **<u>at least</u> 12 consecutive weeks**?		YES	NO
If yes to above, has treatment cessation of omalizumab been attempted?			
YES – please indicate the patient's response and provide rationale for ongoing treatment:			
NO – please provide rationale:			

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: