Nucala (mepolizumab) / Fasenra (benralizumab)

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

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

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

Patient's First Name:	**PHIN:**	**MH Registration Number:**
Patient's Last Name:	**Patient's Date of Birth:**	
Requested Medication Name and Strength:	**Expected Dosing:**	**Expected Therapy Duration:**

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the Part 3 listing. Please provide the following details about how this patient meets the specific criteria for coverage.

Diagnosis/Indication: _____

Patient is inadequately controlled with high-dose inhaled corticosteroids, defined as greater or equal to 500 mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists).

- **Please provide the specific name and dosing frequency of the patient's current asthma medications:**

  Inhaled Corticosteroid: _____ **Dose & Frequency:** _____

  Asthma Controller: _____ **Dose & Frequency:** _____

  Oral Corticosteroid: _____ **Dose & Frequency:** _____

Patient's Baseline Information (Treatment Initiation)			
Nucala/Fasenra Initiation Date: _____			
Baseline eosinophil count (obtained prior to treatment with Nucala/Fasenra): _____**cells/uL** **Date on which result was obtained:** _____			
Total number of clinically significant exacerbations the patient had experienced within the 12 months <u>prior to</u> starting treatment with Nucala/Fasenra: _____			
Baseline Asthma Control Questionnaire (ACQ) Score : _____ **Date on which score was obtained:** _____			
Information for RENEWAL (Complete for EDS Renewal ONLY)			
Total number of clinically significant exacerbations the patient has experienced within the past 12 months <u>after having started</u> treatment with Nucala/Fasenra: _____			
Current Asthma Control Questionnaire (ACQ) Score : _____ **Date on which score was obtained:** _____			
If patient had been on <u>maintenance</u> treatment with an oral corticosteroid (OCS) prior to starting Nucala/Fasenra, please provide the patient's current OCS dose and frequency: _____			
Prescriber Signature and Date:			
Date:		**Prescriber Signature:**	