

## PEGINTERFERON ALFA-2A+RIBAVIRIN/ PEGINTERFERON ALFA-2B+RIBAVIRIN 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:			
PATIENT LAST NAME	FIRST NAME	FIRST NAME			INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services			
DATE OF BIRTH: Year / Month / Day ALBERTA PERS			SONAL HEALTH NUMBER			Other			
STREET ADDRESS CIT		TY		PROV	POSTAL CODE	IDENTIFICAT	ION/CLIENT/	COVERAGE No:	
NOTIFICATION: PATIENT CONSENT:									
You may be eligible to receive Pegetron or Pegasys RBV drug benefits. Information from your prescriber is required to determine eligibility. Your consent is required: (A) for your prescriber to release necessary and relevant information to Alberta Blue Cross, Alberta Health and, if requested, to Alberta Human Services; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health.			I hereby authorize: (A) my prescriber to release to Alberta Blue Cross, Alberta Health, and (if they request it) to Alberta Human Services (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.  Patient's Signature:						
PRESCRIBER INFORMATION									
PRESCRIBER LAST NAME FIRST NAME			INITIAL PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION  CPSA ACO REGISTRATION NO.						
STREET ADDRESS			☐ CARNA ☐ ADA+C						
CITY , PROVINCE			P	HONE: FAX:					
POSTAL CODE				FAX NUMBI	L BER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED				
Drug Requested: Peginterferon Alfa-2a+Ribavirin (E.g. Pegas				BV)	Peginterferon	Alfa-2b+Rib	avirin (E.g.	. Pegetron)	
Diagnosis of chronic hepatitis C:  Is the patient serum HCV RNA positive (by PCR), pre-treatment  YES NO Not Tested									
Evidence of active liver disease:									
At least one of the following:  a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment									
If the patient is currently on Peginterferon Alfa/Ribavirin indicate start date (Year / Month / Day):									
INITIAL REQUEST: EXTENSION REQUEST:									
Initial length of approval:  Advanced fibrosis or cirrhosis (regardless of genotype)			Request for treatment extension at 14 weeks:  For Genotype 1 (non-liver transplant) patients and Genotype 2 or 3 patients with HIV co-infection:  Is the patient serum HCV RNA negative at 12 weeks?						
Is a baseline serum sample stored for future testing?  YES NO				Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)?					
☐ Genotype 2 or 3 with HIV co-infection			YES The patient may be eligible for an additional 14 weeks of therapy to confirm response. Additional serum HCV RNA test results are required at 24 weeks						
Genotype 1, 2 or 3 post-liver transplant26 weeks			Request for treatment extension at 26 weeks:						
Initial and maximum length of approval:			For Genotype 1, 2 or 3 post-liver transplant patients and for patients from the above section that achieved a 2-log drop but were not serum HCV negative at 12 weeks:						
Genotype 2 or 3 (not co-infected with HIV)24 weeks Genotype 4, 5 or 648 weeks			Is the patient serum HCV RNA negative at 24 weeks?  YES NO The patient may be eligible for a total of 48 weeks of therapy.						
PREVIOUS THERAPY: Consideration may be given in patients who have previously received therapy who meet at least one of the following criteria:  Advanced fibrosis or cirrhosis.  Patient relapsed following non-pegylated interferon/ribavirin combination therapy.									
Patient failed to respond to or relapsed following interferon monotherapy									
Additional information relating to request:  PRESCRIBER'S SIGNATURE:  Please forward this request to:									
PRESCRIBER'S SIGNATURE: DATE:			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						