ALBERTA BLUE CROSS®

TELAPREVIR + PEGINTERFERON ALFA/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		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/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. Date: Patient's Signature:

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NO.
STREET ADDRESS			PHONE: / FAX:
CITY , PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug Requested:

☐ **Telaprevir (E.g. Incivek)** **AND ONE OF** ☐ **Peginterferon Alfa-2a+Ribavirin (E.g. Pegasys RBV); OR** ☐ **Peginterferon Alfa-2b+Ribavirin (E.g. Pegetron)**

INITIAL REQUEST: The patient may be eligible for 6 weeks of treatment coverage (6 weeks of telaprevir in combination with peginterferon alfa/ribavirin.). Additional serum HCV RNA test results are required at 4 weeks.

Diagnosis of chronic hepatitis C:	**Evidence of active liver disease:**	
Is the patient serum HCV RNA positive (by PCR), pre-treatment? **YES** ☐ **NO** ☐ **Not Tested** ☐	**At least one of the following:**	**YES** ☐ **NO** ☐ **Not Tested** ☐
	a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment **OR**;	☐ ☐ ☐
Does the patient have HCV Genotype 1? **YES** ☐ **NO** ☐	b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis) **OR:**	☐ ☐ ☐
	c) does the patient have elevated liver stiffness as demonstrated by transient elastography (fibrosis)	☐ ☐ ☐
Does the patient have cirrhosis? **YES** ☐ **NO** ☐	Does the patient have detectable HCV RNA within 6 months from request? **YES** ☐ **NO** ☐	Year / Month / Day
Does the patient have Compensated liver disease (Child Pugh score ≤ 6)? **YES** ☐ **NO** ☐	If patient is currently on Telaprevir + Peginterferon Alfa/Ribavirin indicate start date:	Year / Month / Day

Previous Therapy (please check ONE of the following):

- ☐ **Treatment naïve** (have not received previous therapy with peginterferon alfa/ribavirin)
- ☐ **Null response** (less than 2 logs (100 fold) reduction in HCV RNA after 12 weeks of treatment with peginterferon alfa/ribavirin)
- ☐ **Partial response** (a decrease in HCV RNA vial load greater than or equal to 2 logs (100 fold) by treatment week 12, but failure to achieve a sustained virologic response (SVR) with peginterferon alfa/ribavirin)
- ☐ **Relapse** (undetectable HCV RNA at end of previous therapy with peginterferon alfa/ribavirin but with subsequently detectable HCV RNA)
- ☐ **Other** (please specify):

WEEK 4 EXTENSION REQUEST: The patient may be eligible for an additional 6 weeks of telaprevir therapy (total duration of 12 weeks) plus an additional 8 weeks of peginterferon alfa/ribavirin. Additional serum HCV RNA test results are required at 12 weeks.	**WEEK 12 EXTENSION REQUEST:** The patient may be eligible for additional therapy with peginterferon alfa/ribavirin, as per published criteria. Additional serum HCV RNA test results are required at 24 weeks.
Is the patient serum HCV RNA detectable at 4 weeks? **YES** ☐ **NO** ☐	Is the patient serum HCV RNA detectable at 12 weeks? **YES** ☐ **NO** ☐
Is the patient serum HCV RNA less than 1000 IU/mL at 4 weeks? **YES** ☐ **NO** ☐	Is the patient serum HCV RNA less than 1000 IU/mL at 12 weeks? **YES** ☐ **NO** ☐

WEEK 24 EXTENSION REQUEST: The patient may be eligible for an additional 22 weeks of peginterferon alfa/ribavirin therapy (total 48 weeks peginterferon alfa/ribavirin).

Is the patient serum HCV RNA detectable at 24 weeks? **YES** ☐ **NO** ☐

Additional information relating to request:

PRESCRIBER'S SIGNATURE:	DATE:	Please forward this request to: • **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