ALBERTA BLUE CROSS®

BOCEPREVIR + 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

PATIENT LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

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.

PATIENT CONSENT:

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

STREET ADDRESS

CITY , PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA ☐ ACO
- ☐ CARNA ☐ ADA+C
- ☐ ACP ☐ Other

REGISTRATION NO.

PHONE: FAX:

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug Requested:

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

INITIAL REQUEST: Select patients may be eligible for a 4 week run-in period with peginterferon alfa/ribavirin prior to the initiation of boceprevir PLUS 10 weeks of boceprevir in combination with peginterferon alfa/ribavirin. Additional serum HCV RNA test results are required at boceprevir weeks 4 and 8 (i.e. treatment weeks 8 and 12). Patients with compensated cirrhosis and/or with prior null response may be eligible for coverage of boceprevir and peginterferon alfa/ribavirin for a total of 44 weeks of boceprevir and 48 weeks of peginterferon alfa/ribavirin.

Diagnosis of chronic hepatitis C:

Is the patient serum HCV RNA positive (by PCR), pre-treatment?
YES ☐ **NO** ☐ **Not Tested** ☐

Does the patient have HCV Genotype 1?
YES ☐ **NO** ☐

Does the patient have cirrhosis?
YES ☐ **NO** ☐

Does the patient have Compensated liver disease (Child Pugh score ≤ 6)?
YES ☐ **NO** ☐

Evidence of active liver disease:

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; 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 detectable HCV RNA within 6 months from request? **YES** ☐ **NO** ☐ — Year / Month / Day

If the patient is currently on Boceprevir + 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):

FIRST EXTENSION REQUEST:

The patient may be eligible for an additional 14 weeks of coverage. Additional serum HCV RNA test results are required at boceprevir week 20 (i.e. treatment week 24).

	YES	NO
Is the patient serum HCV RNA detectable at boceprevir week 4 (i.e. treatment week 8)?	☐	☐
Is the patient serum HCV RNA less than 100 IU/mL at boceprevir week 8 (i.e. treatment week 12)?	☐	☐

SECOND EXTENSION REQUEST:

The patient may be eligible for additional therapy with peginterferon alfa/ribavirin +/- boceprevir up to week 48 as per published criteria.

Is the patient serum HCV RNA detectable at boceprevir week 20 (i.e. treatment week 24)?
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