

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				COVERAGE TYPE
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other	
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> CARNA <input type="checkbox"/> ACP	<input type="checkbox"/> ACO <input type="checkbox"/> ADA+C <input type="checkbox"/> Other	REGISTRATION NUMBER
			CITY, PROVINCE	PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

**Please provide the following information for ALL requests**

Indicate which MS disease modifying therapy (DMT) is requested (check one box)

**Gilenya** (fingolimod)       **Mavenclad** (cladribine) → provide patient weight (kg) \_\_\_\_\_       **Tysabri** (natalizumab)

**NEW request** (i.e. new to MS DMT and/or coverage)       **RENEWAL request**       **RESTART request**       **MS DMT SWITCH**

For patients already on the requested MS DMT, specify start date (YYYY-MM-DD) \_\_\_\_\_

For patients already on cladribine, also specify the number of treatment courses and doses/course administered \_\_\_\_\_

<b>Diagnosis</b>	<b>Current *EDSS</b> _____ Date _____
<input type="checkbox"/> Relapsing-remitting multiple sclerosis <input type="checkbox"/> Other (please specify) _____	<b>*If the current EDSS is 7.0 or above, has the EDSS score been sustained at 7.0 or above for one year or more?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Please provide the following information for all NEW requests and for RESTART after treatment interruption**

**Qualifying relapses: Provide the dates of two relapses within the last two years OR the two years prior to starting MS DMT**

Date of relapse (YYYY-MM-DD)	Type of relapse (One MRI relapse may substitute for one clinical relapse)
	<input type="checkbox"/> Clinical relapse <input type="checkbox"/> MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	<input type="checkbox"/> Clinical relapse <input type="checkbox"/> MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

a) Has the patient been on MS DMT of any kind since the relapse(s)?     No       Yes → If yes, answer b) and c)

b) Specify the MS DMT start date (YYYY-MM-DD) \_\_\_\_\_

c) Indicate if there have been any interruptions in therapy since starting MS DMT     No     Yes → If yes, indicate

i) Reason for the interruption in therapy \_\_\_\_\_

ii) Specify time period of interruption: **from** (YYYY-MM-DD) \_\_\_\_\_ **to** (YYYY-MM-DD) \_\_\_\_\_

iii) How many relapses did the patient experience while off therapy? \_\_\_\_\_

**NEW and SWITCH requests: Provide response to ONE of the following MS DMT**  
 DIMETHYL FUMARATE; GLATIRAMER ACETATE; INTERFERON BETA; OCRELIZUMAB; PEGINTERFERON BETA; TERIFLUNOMIDE

**Name of MS DMT utilized** \_\_\_\_\_ **and date of treatment initiation (YYYY-MM-DD)** \_\_\_\_\_

**INTOLERANCE** despite the use of symptom management techniques; **OR**  **REFRACTORY** → answer a) and b)

a) Does the patient have clinically significant titres of neutralizing antibodies to interferon beta?     Yes     No     N/A

b) Within a consecutive 12-month period while on the MS DMT, did the patient experience at least two relapses of MS?  
 No     Yes → **Provide the dates of either 2 clinical relapses OR 1 clinical relapse and 1 MRI relapse**

Date of relapse (YYYY-MM-DD)	Type of relapse (One MRI relapse may substitute for one clinical relapse)
	<input type="checkbox"/> Moderate to very severe clinical relapse <input type="checkbox"/> MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	<input type="checkbox"/> Moderate to very severe clinical relapse <input type="checkbox"/> MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

**Fingolimod or Natalizumab RENEWAL requests and NEW requests for patients already on drug, please provide the following information**

a) Has the patient experienced **more than one** relapse event per year since starting treatment?     Yes     No

b) If yes and the patient experienced four or more relapses in the year prior to starting treatment, has the patient demonstrated a 50 per cent reduction in relapse events since starting treatment?     Yes     No

**Please provide the following information for the first natalizumab RENEWAL request only**

**Natalizumab neutralizing antibody test result**

Negative for natalizumab antibodies       Positive for natalizumab antibodies      Date of the test \_\_\_\_\_

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to <b>Alberta Blue Cross, Clinical Drug Services</b> 10009 108 Street NW, Edmonton, Alberta T5J 3C5 FAX 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas
------------------------	-------------------	--

**ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE FAX YOUR REQUEST.**

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

© The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan. © † Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association. ABC 60000 (2020/07)

