ALBERTA BLUE CROSS®

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

NATALIZUMAB
SPECIAL AUTHORIZATION REQUEST FORM

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:

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

Please provide the following information for ALL requests:

☐ **NEW request** (i.e. new to natalizumab and/or coverage). **If patient is already on natalizumab, specify date started:** _____

☐ **RENEWAL request** ☐ **RESTART request** ☐ **MS disease modifying therapy (DMT) Switch**

Diagnosis

☐ Relapsing-remitting multiple sclerosis

☐ Other (please specify):_____

Current *EDSS: _____. _____ Date:_____

***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? ☐ Yes ☐ No

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

Qualifying Relapses: Provide the dates of 2 relapses within the last 2 years, OR the 2 years prior to starting MS DMT

Date of Relapse (YYYY/MM/DD)	**Type of Relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))

a) Has the patient been on MS DMT since the relapse(s)? ☐ No ☐ Yes

b) 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 requests: Provide response to TWO of the following: INTERFERON BETA; GLATIRAMER ACETATE; DIMETHYL FUMARATE; TERIFLUNOMIDE

Name of 1st MS DMT utilized: _____ **and date of treatment initiation (YYYY/MM/DD):** _____

☐ **INTOLERANCE** despite the use of symptom management techniques; **OR**

☐ **REFRACTORY** → 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)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))

Name of 2nd MS DMT utilized: _____ **and date of treatment initiation (YYYY/MM/DD):** _____

☐ **INTOLERANCE** despite the use of symptom management techniques; **OR**

☐ **REFRACTORY** → 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)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s))

Please provide the following information for all RENEWAL requests and NEW requests when patient is already on natalizumab:

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

b) If yes and the patient experienced 4 or more relapses in the year prior to starting treatment, has the patient demonstrated a 50% reduction in relapse events since starting treatment? ☐ Yes ☐ No

Please provide the following information for the first RENEWAL request only

Natalizumab neutralizing antibody test result:

☐ Negative for natalizumab antibodies ☐ Positive for natalizumab antibodies Date of the test: _____

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

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