ALBERTA BLUE CROSS®

IVACAFTOR
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
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
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

☐ **NEW Please provide the following information for NEW requests**

Diagnosis

☐ Cystic Fibrosis

☐ Other (please specify) _____

Mutation affecting the *Cystic Fibrosis Transmembrane conductance Regulator (CFTR)* gene

☐ G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R

☐ R117H

☐ Other (please specify) _____

Please provide the following pre-treatment information for NEW requests

Sweat Chloride test (mmol/L)	Date
FEV_1 (pre-bronchodilator % predicted)	Date

☐ **RENEWAL Please provide the following current information for RENEWAL requests**

Initial renewal		**Subsequent renewals**	
Sweat Chloride test (mmol/L)	Date	Sweat Chloride test (mmol/L)	Date
FEV_1 (pre-bronchodilator % predicted) one month after starting treatment	Date	FEV_1 (pre-bronchodilator % predicted)	Date
FEV_1 (pre-bronchodilator % predicted) three months after starting treatment	Date		

Note: If the expected reduction in sweat chloride does not occur, the patient's CF clinician will first explore any problems in following the recommended dosing schedule for ivacaftor. The patient's sweat chloride will then be re-tested around one week later and funding discontinued if the patient does not meet criteria.

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

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