

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"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			PHONE	FAX	
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) <u>one</u> month after starting treatment	Date	FEV ₁ (pre-bronchodilator % predicted)	Date
FEV ₁ (pre-bronchodilator % predicted) <u>three</u> 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
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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.

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