ALBERTA BLUE CROSS®

SIMEPREVIR + 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				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH:YYYY/MM/DD	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

NOTIFICATION	**PATIENT CONSENT**
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.	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	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug Requested

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

INITIAL REQUEST: The patient may be eligible for six weeks of treatment coverage (six weeks of simeprevir in combination with peginterferon alfa/ribavirin.). Additional serum HCV RNA test results are required at four weeks

Diagnosis of chronic hepatitis C

1) Is the patient serum HCV RNA positive (by PCR), pre-treatment?	**YES** ☐	**NO** ☐	**Not Tested** ☐
2a) Does the patient have HCV Genotype 1?	**YES** ☐	**NO** ☐	**Not Tested** ☐
b) **If yes,** does the patient have subtype 1a HCV?	**YES** ☐	**NO** ☐	**Not Tested** ☐
c) **If yes,** does the patient have confirmed Q80K polymorphism?	**YES** ☐	**NO** ☐	**Not Tested** ☐
3) Does the patient have Compensated liver disease (Child Pugh score ≤ 6)?	**YES** ☐	**NO** ☐	
4) Does the patient have detectable HCV RNA within the last six months?	**YES** ☐	**NO** ☐	Test date (YYYY/MM/DD)
5) Does the patient have a fibrosis stage of F2, F3, or F4?	**YES** ☐	**NO** ☐	
6) If patient is currently on Simeprevir + Peginterferon Alfa/Ribavirin indicate start date (YYYY/MM/DD)			

Previous Therapy (please check ONE of the following)

- ☐ **Treatment naïve** (have not received previous therapy with peginterferon alfa/ribavirin)
- ☐ **Null response** (less than two 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 two 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) _____

WEEK 4 EXTENSION REQUEST: The patient may be eligible for an additional six weeks of simeprevir therapy (total duration of 12 weeks) plus an additional eight weeks of peginterferon alfa/ribavirin. Additional serum HCV RNA test results are required at treatment week 12

Is the patient serum HCV RNA detectable at four weeks?	**YES** ☐	**NO** ☐
Is the patient serum HCV RNA less than 25 IU/mL at four weeks?	**YES** ☐	**NO** ☐

WEEK 12 EXTENSION REQUEST: The patient may be eligible for additional therapy with peginterferon alfa/ribavirin, as per published criteria. Additional serum HCV RNA test results are required at treatment week 24

Is the patient serum HCV RNA detectable at 12 weeks?	**YES** ☐	**NO** ☐

WEEK 24 EXTENSION REQUEST: The patient may be eligible for an additional 22 weeks of peginterferon alfa/ribavirin therapy (total 48 weeks peginterferon alfa/ribavirin)

Is the patient serum HCV RNA detectable at 24 weeks?	**YES** ☐	**NO** ☐

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