ALBERTA BLUE CROSS®

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

VALGANCICLOVIR
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

Criteria for Coverage of VALGANCICLOVIR

For the treatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS). Special authorization may be granted for 12 months.

For the prevention of CMV disease in solid organ transplant patients at risk (i.e. risk is defined as donor +ve/recipient -ve for CMV, or recipient +ve for CMV, or recipient +ve in patients receiving antilymphocyte antibody [ALA]). For the purpose of administering this criterion, islet transplant recipients are at similar risk of CMV disease to patients undergoing a solid organ transplant and qualify for drug coverage. Special authorization may be granted for 100 days.

For the prevention of CMV disease in kidney transplant patients at risk (i.e. risk is defined as donor +ve/recipient -ve for CMV, or recipient +ve for CMV, or recipient +ve in patients receiving antilymphocyte antibody [ALA]). Special authorization may be granted for 200 days.

Section I (Valganciclovir requests for the first criterion):

a) Does the patient have CMV Retinitis? ☐ Yes ☐ No

b) Does the patient have HIV/AIDS? ☐ Yes ☐ No

Section II (Valganciclovir requests for Criterion 2 & 3):

a) Is this request for prevention of CMV Disease?

☐ Yes ☐ No, specify:_____

b) Has the patient had a solid organ transplant?

☐ Yes → i) Date of transplant:_____ ii) Specify which organ(s) were transplanted:_____

☐ No

c) CMV Serostatus (check ONE of the following):

☐ CMV mismatch i.e. Donor +ve/Recipient –ve for CMV

☐ Recipient +ve for CMV

d) Therapy (check ALL that apply):

☐ ALA therapy → provide most recent treatment date: _____

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.