

VALGANCICLOVIR 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

PATIENT INFORMATION							COVERAGE TYPE:		
PATIENT LAST NAME	FIRST NAME	FIRST NAME			T i		COVERAGE THE.		
TATIENT LACTIVAME	TIKOTIVAWE					INITIAL	Alberta Blue Cross		
DATE OF DIDTH V							Alberta Human Services Other		
DATE OF BIRTH: Year / Month / Day	ALBERTAPE	ALBERTA PERSONAL HEALT				H NUMBER		ы	
STREET ADDRESS	CITY	CITY		ROV POSTAL CODE		IDENTIFICATION/CLIENT/COVERAGE No:			
PRESCRIBER INFORMATION									
PRESCRIBER LAST NAME FIRST NAME INITIAL PRESCRIBE						R PROFESSIONAL ASSOCIATION REGISTRATION			
				☐ CPSA ☐ ACO REGISTRATION NO.					
STREET ADDRESS			[CARNA ADA+C					
			<u> </u>	□ ACP □ Other PHONE: FAX			FAX:		
CITY , PROVINCE				FIIONE.			FAX.		
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POSTAL CODE				EAVABLINADED MULOT DE DDOVU					
1 OOTAL GODE								JST BE PROVIDED WITH EACH QUEST SUBMITTED	
Criteria for Coverage of VALGANCICLOVIR					TREADED! GOS.III.1125				
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?									
b) Does the patient have HIV/AIDS?									
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:									
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	a following):								
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 r	equest:								
PRESCRIBER'S SIGNATURE	DATE	E Please forward							
■ Alber				ta Blue Cross, Clinical Drug Services 0-108 Street NW, Edmonton, Alberta T5J 3C5					
								28-4106 toll free all other areas	
ONCE VOLID DECLIEST HAS SUCCESSELLLY TRANSMITTED DI EASE DO NOT MAIL OR DE EAY VOLID DECLIEST									

The information collected by this form is collected 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 purpose of determining or In a minimal confected by this formation and Protection of Privacy Act, for the purpose 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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