

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	<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	
POSTAL CODE			PHONE	FAX	
			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

1) Indicate the requested drug regimen and the patient's Hepatitis C Virus (HCV) Genotype

*Drug regimen requested	Corresponding HCV genotype
<input type="checkbox"/> Elbasvir/grazoprevir (e.g. Zepatier) +/- ribavirin (e.g. Ibavyr)	<input type="checkbox"/> Genotype 1 → Specify subtype _____ <input type="checkbox"/> Genotype 4
<input type="checkbox"/> Glecaprevir/pibrentasvir (e.g. Maviret)	Genotype _____ (optional if treatment naïve)
<input type="checkbox"/> Sofosbuvir (e.g. Sovaldi) + daclatasvir (e.g. Daklinza)	<input type="checkbox"/> Genotype 3
<input type="checkbox"/> Sofosbuvir (e.g. Sovaldi) + ribavirin (e.g. Ibavyr)	<input type="checkbox"/> Genotype 2 <input type="checkbox"/> Genotype 3
<input type="checkbox"/> Sofosbuvir/ledipasvir (e.g. Harvoni) +/- ribavirin (e.g. Ibavyr)	<input type="checkbox"/> Genotype 1
<input type="checkbox"/> Sofosbuvir/velpatasvir (e.g. Epclusa) +/- ribavirin (e.g. Ibavyr)	Genotype _____ (optional)
<input type="checkbox"/> Sofosbuvir/velpatasvir/voxilaprevir (e.g. Vosevi)	Genotype _____ (optional if prior NS5A inhibitor)

*Duration of therapy and coverage of ribavirin in combination with the selected drug regimen will be approved according to criteria specified in the *Alberta Drug Benefit List*.

2 a) Does the patient have a quantitative HCV RNA value within six months of this request?

Yes → Provide test date (YYYY-MM-DD) _____ No Not tested

2 b) For sofosbuvir/ledipasvir requests, is the patient's most recent viral load greater than 6 M IU/mL? Yes No

3) What is the patient's fibrosis stage (optional)? F0 F1 F2 F3 F4 Not tested

4) Does the patient have cirrhosis?

Yes, compensated cirrhosis with Child-Turcotte-Pugh A (i.e. score five to six)
 Yes, decompensated cirrhosis with Child-Turcotte-Pugh B or C (i.e. score seven or above)
 No

5) Is treatment requested post liver transplant? Yes No

6) Has the patient previously been treated with an HCV antiviral drug regimen?

Yes → Specify drug regimen previously used _____
 → Specify the patient's response
 failure (i.e. null or partial response or virologic breakthrough/rebound) intolerance relapse
 other; specify _____
 No, the patient is treatment-naïve

7) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) _____

8) Indicate the specialist consulted, where applicable _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	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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