ALBERTA BLUE CROSS®

SOFOSBUVIR/LEDIPASVIR 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

PATIENT LAST NAME	FIRST NAME		INITIAL
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER		
STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

ID/CLIENT/COVERAGE NUMBER

NOTIFICATION

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.

PATIENT CONSENT

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
STREET ADDRESS		
CITY, PROVINCE		
POSTAL CODE		

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA ☐ ACO
- ☐ CARNA ☐ ADA+C
- ☐ ACP ☐ Other

REGISTRATION NUMBER

PHONE	FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Diagnosis of chronic hepatitis C

	Question	Response
1)	Is the patient serum HCV RNA positive (by PCR), pre-treatment?	**Yes** ☐ **No** ☐ **Not tested** ☐
2)	Does the patient have HCV Genotype 1?	**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 6 months from request?	**Yes** ☐ test date (YYYY/MM/DD) ___________ **No** ☐
5)	Does the patient have a fibrosis stage of F2, F3, or F4?	**Yes** ☐ (specify stage) _______________ **No** ☐
6)	Does the patient have cirrhosis?	**Yes** ☐ **No** ☐
7)	Is the patient's viral load ≥ 6 M IU/mL?	**Yes** ☐ **No** ☐
8)	Is the patient co-infected with HIV?	**Yes** ☐ **No** ☐
9)	If the patient is currently on sofosbuvir/ledipasvir please indicate the start date (YYYY/MM/DD) ______________________	

Previous therapy (please check ONE of the following)

- ☐ **Treatment naïve** (no prior exposure to any interferon, ribavirin, or other approved or experimental HCV-specific direct-acting antiviral agent at the time of treatment initiation)
- ☐ **Treatment experienced** (failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor)
- ☐ **Other** (please specify):

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

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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