ALBERTA BLUE CROSS®

OMBITASVIR/PARITAPREVIR/RITONAVIR+ DASABUVIR
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**
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 REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please note: Where special authorization criteria have been satisfied, patients will be approved for coverage of Ombitasvir/Paritaprevir/Ritonavir+Dasabuvir (e.g. Holkira Pak) alone or in combination with Ribavirin as outlined in the special authorization criteria ("Duration of therapy reimbursed" section)

Diagnosis of chronic hepatitis C

1) Is the patient serum HCV RNA positive (by PCR), pre-treatment? **YES** ☐ **NO** ☐ **Not Tested** ☐

2) Please indicate the patient's HCV Genotype: ☐ Genotype 1a ☐ Genotype 1b ☐ Genotype 1 unknown subtype
☐ Genotype 1 mixed infection ☐ Not Tested ☐ Other (Specify) _____

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) If the patient is currently on ombitasvir/paritaprevir/ritonavir+dasabuvir please indicate the start date (YYYY/MM/DD) _____

Previous therapy: please check ALL that apply

☐ **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** (previously been treated with PegINF/RBV and did NOT receive adequate response)

→ **For genotype 1a cirrhotic patients ONLY, please check one of the following**

☐ Prior relapse ☐ Partial responder ☐ Prior null response ☐ Other (please specify)_____

☐ **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

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST