ALBERTA BLUE CROSS®

ECULIZUMAB CONSENT FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER M/F	DATE OF BIRTH (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

ID/CLIENT/COVERAGE NUMBER	COVERAGE TYPE	
		☐Alberta Blue Cross ☐Alberta Human Services ☐Other

SPECIALIST IN HEMATOLOGY INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

TELEPHONE NUMBER	FAX NUMBER	COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER

PATIENT CONSENT FOR SERVICE

I have received a copy of the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (the Policy) and have read and understand the requirements of a patient receiving Alberta government sponsored funded treatment.

I agree to comply with the requirements for coverage as set out in the Policy, including (without limitation) the requirements for monitoring, review and data collection.

I understand and agree that I must continue to qualify for, and continue to be a member of, an Alberta government sponsored drug program to continue to be eligible for eculizumab coverage in accordance with the Policy.

I understand and agree that approval for initial and continued coverage is conditional upon meeting and continuing to meet the requirements of the Policy.

I understand that my consent must be and is ongoing and my failure to comply with the requirements as set out in the Policy may preclude me from continuing to be eligible for eculizumab coverage.

I understand that prior to potential discontinuance of eculizumab coverage, as outlined in the Policy, my Specialist in Hematology will receive notice of this in writing. I understand that my Specialist in Hematology has a responsibility to notify me, and to work with me to address the reason for potential withdrawal of eculizumab coverage.

I understand that therapy may be withdrawn at the request of the patient or the patient's parent/guardian at any time. Notification of withdrawal from therapy must be made by the Specialist in Hematology or patient in writing. I understand there may be side effects from medication and I have discussed the risks and benefits of this treatment with my Specialist in Hematology.

I, either as the patient or as the patient's parent/guardian (as appropriate), and on behalf of the patient's heirs and my estate and any other person claiming through the patient, hereby release the Minister, the Minister's delegate, the Minister's agents and employees from any and all liability and all claims for any and all damages, injuries, loss and costs which may arise directly or indirectly in relation to or in connection with the Application and coverage, funding and use of eculizumab for the patient pursuant to the Policy, including (without limitation) all claims relating to coverage, any changes in coverage, any restrictions or conditions of coverage, discontinuance of coverage, and the patient's use of eculizumab. I agree and acknowledge that this release is binding on the patient, the patient's heirs and estate, and any other person claiming through the patient against the Minister, the Minister's agents and employees.

Name of patient ______________________________

Signature of patient (for patients > or equal to 18 years old) ______________________ Date ____________

Name of parent/guardian (for patients <18 years old) ______________________________

Signature of parent/guardian (for patients <18 years old) ______________________ Date ____________

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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PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

I give consent for my Specialist in Hematology to disclose relevant health registration, assessment, diagnostic, and treatment information to, the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy) for the purpose of determining my initial and continued eligibility for, or discontinuance of, eculizumab coverage. I understand that the Expert Advisors are specialists engaged by the Alberta government to provide advice to the Minister or the Minister's delegate in accordance with the Policy.

I also give consent to the Minister, the Minister's delegate, the Minister's employees and agents, the Alberta government, the Alberta government's employees and agents, Alberta Blue Cross, Alberta Blue Cross's employees and agents, and one or more Expert Advisors as referred to in the Policy to disclose relevant health registration, assessment, diagnostic, and treatment information to each other and to my Specialist in Hematology, for the purpose of determining my initial and continued eligibility for, or discontinuance of, eculizumab coverage.

I understand that I have been asked to disclose my health information in order to determine eligibility for funding for eculizumab and payment for this drug. I understand the risks and benefits of consenting or refusing to consent. I understand that I may revoke this consent at any time by giving notice in writing to Alberta Blue Cross at the address below. I understand and agree that if I revoke this consent, this revocation is deemed a request for withdrawal of coverage.

This consent is effective on execution and will remain in effect unless revoked with notice in writing.

Name of patient ____

Signature of patient (for patients > or equal to 18 years old) ______________________ Date ______________

Name of parent/guardian (for patients <18 years old) ______________________________________

Signature of parent/guardian (for patients <18 years old) ______________________ Date ______________

SPECIALIST IN HEMATOLOGY CONSENT

I agree to comply with the requirements for monitoring, review and data collection as set out in the policy relating to Eculizumab in the current version of the Alberta Drug Benefit List (ADBL), as updated from time to time (hereinafter referred to as the Policy).

I understand that information about the patient's ongoing eligibility, and possible discontinuation (if appropriate), will be supplied to me, and that I will be responsible for passing this information on to my patient or my patient's parent/guardian.

I understand that reviews of my patient will be ongoing and my failure to provide monitoring data on behalf of my patient, as set out in the Policy, may preclude my patient from continuing to receive Alberta government funded treatment.

I understand that prior to the potential withdrawal of eculizumab coverage as outlined in the Policy, I will receive notice of this in writing. I understand that it is my responsibility to notify my patient and work with my patient to address the reason for potential withdrawal of eculizumab coverage.

I have provided my patient or my patient's parent/guardian with the Policy so that they are aware of the requirements of a patient receiving Alberta government sponsored funded treatment. I have also read the Policy and understand what is required of me, as the treating physician.

Name of specialist in hematology ____

Signature of specialist in hematology ______________________________ Date ______________

Completed Eculizumab Consent Forms or written withdrawal of consent should be directed by mail or FAX to:

Alberta Blue Cross, Clinical Drug Services
10009 108 Street NW, Edmonton, Alberta T5J 3C5
FAX: **780-401-1150** in Edmonton • **1-888-401-1150** toll free all other areas

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