ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

PEGINTERFERON ALFA-2A+RIBAVIRIN/ PEGINTERFERON ALFA-2B+RIBAVIRIN SPECIAL AUTHORIZATION REQUEST FORM

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

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL
BIRTH DATE (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

You may be eligible to receive Pegetron or Pegasys RBV drug benefits. 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

Drug Requested: ☐ **Peginterferon Alfa-2a+Ribavirin (e.g. Pegasys RBV)** ☐ **Peginterferon Alfa-2b+Ribavirin (e.g. Pegetron)**

Diagnosis of chronic hepatitis C	**YES**	**NO**	**Not tested**
Is the patient serum HCV RNA positive (by PCR), pre-treatment……	☐	☐	☐

Evidence of active liver disease

At least one of the following	**YES**	**NO**	**Not tested**
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment……..	☐	☐	☐
OR			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis)……	☐	☐	☐
OR			
c) does the patient have elevated liver stiffness as demonstrated by transient elastography (fibrosis)……	☐	☐	☐

If the patient is currently on Peginterferon Alfa/Ribavirin indicate start date (YYYY/MM/DD)

INITIAL REQUEST

Initial length of approval

- ☐ **Advanced fibrosis or cirrhosis** (regardless of genotype)…….... 48 weeks
- ☐ **Genotype 1**……14 weeks
  - Is a baseline serum sample stored for future testing?
  - ☐ YES ☐ NO
- ☐ **Genotype 2 or 3 with HIV co-infection**……..14 weeks
  - Is a baseline serum sample stored for future testing?
  - ☐ YES ☐ NO
- ☐ **Genotype 1, 2 or 3 post-liver transplant**……....26 weeks

Initial **and maximum** length of approval

- ☐ **Genotype 2 or 3** (not co-infected with HIV)...……24 weeks
- ☐ **Genotype 4, 5 or 6**…..……48 weeks

EXTENSION REQUEST

Request for treatment extension at 14 weeks

For Genotype 1 (non-liver transplant) patients and Genotype 2 or 3 patients with HIV co-infection

Is the patient serum HCV RNA negative at 12 weeks?

- ☐ YES Patient may be eligible for an additional 34 weeks of coverage (total 48 weeks)
- ☐ NO Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)?
  - ☐ YES The patient may be eligible for an additional 14 weeks of therapy to confirm response. Additional serum HCV RNA test results are required at 24 weeks
  - ☐ NO

Request for treatment extension at 26 weeks

For Genotype 1, 2 or 3 post-liver transplant patients and for patients from the above section that achieved a 2-log drop but were not serum HCV negative at 12 weeks

Is the patient serum HCV RNA negative at 24 weeks?

☐ YES ☐ NO The patient may be eligible for a total of 48 weeks of therapy

PREVIOUS THERAPY: Consideration may be given in patients who have previously received therapy who meet at least one of the following criteria

- ☐ Advanced fibrosis or cirrhosis
- ☐ Patient relapsed following non-pegylated interferon/ribavirin combination therapy
- ☐ Patient failed to respond to or relapsed following interferon monotherapy

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