ALBERTA BLUE CROSS®

# PEGINTERFERON ALFA-2A for Chronic Hepatitis C
# 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 |
|---|---|---|
| | | |

| 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 Pegasys 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 REGISTRATION NUMBER
☐ CARNA ☐ ADA+C
☐ ACP ☐ Other

PHONE | FAX

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

## 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-2a, indicate start date** (YYY-MM-DD):

## INITIAL REQUEST:

Is the patient intolerant to ribavirin? ☐ YES ☐ NO

Is a baseline serum sample stored for future testing? ☐ YES ☐ NO

Initial length of approval

- ☐ **Advanced fibrosis or cirrhosis** (regardless of genotype)…...48 weeks
- ☐ **Genotype 1**……..……..……14 weeks
- ☐ **Genotype 2 or 3** ……..……14 weeks
- ☐ **Genotype 4, 5 or 6** ……14 weeks

## EXTENSION REQUEST:

**Request for treatment extension at 14 weeks (excluding patients with advanced fibrosis and cirrhosis)**

Is the patient serum HCV RNA negative at 12 weeks?

- ☐ YES → Patient may be eligible for an additional 34 weeks of coverage (total 48 wks)
- ☐ NO → Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)?
  - ☐ YES → Patient may be eligible for an additional 34 weeks of coverage (total 48 wks)
  - ☐ NO

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

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

**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**