ALBERTA BLUE CROSS®

# ASFOTASE ALFA 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 | INITIAL | ☐ Alberta Blue Cross<br>☐ Alberta Human Services<br>☐ Other |
|---|---|---|---|
| BIRTH DATE (YYYY-MM-DD) | ALBERTA PERSONAL HEALTH NUMBER | | |

| STREET ADDRESS | CITY | PROV | POSTAL CODE | ID/CLIENT/COVERAGE NUMBER |
|---|---|---|---|---|
| | | | | |

## METABOLIC SPECIALIST INFORMATION

| PRESCRIBER LAST NAME | FIRST NAME | INITIAL | COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NUMBER | |
|---|---|---|---|---|
| STREET ADDRESS | | | PHONE | FAX |
| CITY, PROVINCE | | | | |
| POSTAL CODE | | | FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED | |

## PATIENT CONSENT FOR SERVICE

I have received a copy of the policy relating to asfotase alfa 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 asfotase alfa 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 asfotase alfa coverage.

I understand that prior to potential discontinuance of asfotase alfa coverage, as outlined in the Policy, my Metabolic Specialist will receive notice of this in writing. I understand that my Metabolic Specialist has a responsibility to notify me, and to work with me to address the reason for potential withdrawal of asfotase alfa 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I understand that therapy may be withdrawn at the request of the patient or the patient's parent/guardian at any time.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 Metabolic Specialist 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 Metabolic Specialist.

I, either as the patient or as the patient's parent or 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 asfotase alfa 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 asfotase alfa. 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 18 years of age or older) _____ Date _____

Name of parent or guardian (for patients under the age of 18) _____

Signature of parent or guardian (for patients under the age of 18) _____ Date _____

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## PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

I give consent for my Metabolic Specialist 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 asfotase alfa 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, asfotase alfa 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 Metabolic Specialist, for the purpose of determining my initial and continued eligibility for, or discontinuance of, asfotase alfa coverage.

I understand that I have been asked to disclose my health information in order to determine eligibility for funding for asfotase alfa 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 18 years of age or older) _____ Date _____

Name of parent or guardian (for patients under the age of 18) _____

Signature of parent or guardian (for patients under the age of 18) _____ Date _____

## METABOLIC SPECIALIST CONSENT

I agree to comply with the requirements for monitoring, review and data collection as set out in the policy relating to asfotase alfa 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 or 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 asfotase alfa 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 asfotase alfa coverage.

I have provided my patient or my patient's parent or 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 Metabolic Specialist _____

Signature of Metabolic Specialist _____ Date _____

Completed consent form 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