

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other	
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO
			<input type="checkbox"/> CARN	<input type="checkbox"/> ADA+C
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for ALL requests

1) Drug requested <input type="checkbox"/> Praluent <input type="checkbox"/> Repatha	2) Dosage and frequency
3) Diagnosis	
<input type="checkbox"/> Definite or Probable diagnosis of heterozygous familial hypercholesterolemia (HeFH) → Was the diagnosis confirmed using the Simon Broome or Dutch Lipid Network criteria, or genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other (specify) _____	

Please provide the following information for INITIAL requests for treatment-naive and treatment-experienced patients

1) Pre-treatment Low Density Lipoprotein-Cholesterol (LDL-C) _____ (mmol/L) Date _____	
<i>Note Pre-treatment refers to the LDL-C level taken prior to initiation of the requested drug, rather than the untreated baseline LDL-C level.</i>	
2) Previous therapy (check the applicable box)	
<input type="checkbox"/> Adherence to high dose statin (e.g. atorvastatin 80 mg or rosuvastatin 40 mg) <u>in combination</u> with ezetimibe for at least three months → Specify statin utilized _____ Dose _____	
OR	
<input type="checkbox"/> Adherence to ezetimibe for at least three months [please confirm if patient meets a) or b) below by checking the applicable box]	
→ a) <input type="checkbox"/> Statins are contraindicated (specify) _____	
→ b) <input type="checkbox"/> Patient was unable to tolerate high dose statin [please complete i) to v) below]	
i) Inability to tolerate at least two statins with at least one started at the lowest starting daily dose [specify 2 statins utilized including dose and check ALL that apply for ii) to v) for each statin below]	
<input type="checkbox"/> Statin #1 _____ Dose _____ <input type="checkbox"/> Statin #2 _____ Dose _____	
ii) Dose reduction is attempted for intolerable symptom (myopathy) or biomarker abnormality [creatinine kinase (CK) > five times the upper limit of normal (ULN)] resolution rather than discontinuation of statin altogether	<input type="checkbox"/> Statin #1 <input type="checkbox"/> Statin #2
iii) Intolerable symptoms (myopathy) or abnormal biomarkers (CK > five times the ULN) changes are reversible upon statin discontinuation but reproducible by re-challenge of statins where clinically appropriate	<input type="checkbox"/> Statin #1 <input type="checkbox"/> Statin #2
iv) Other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out	<input type="checkbox"/> Statin #1 <input type="checkbox"/> Statin #2
v) Patient developed confirmed and documented rhabdomyolysis	<input type="checkbox"/> Statin #1 <input type="checkbox"/> Statin #2
3) Despite the above previous therapy, is the patient unable to reach LDL-C target (i.e., LDL-C < 2.0 mmol/L for secondary prevention or at least a 50% reduction in LDL-C from untreated baseline for primary prevention)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4) If the patient is currently on the requested drug, please indicate start date (YYYY-MM-DD) _____	

Please provide the following information for RENEWAL requests and for INITIAL requests for treatment-experienced patients

1) Is the patient adherent to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	2) Current LDL-C _____ (mmol/L) Date _____
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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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

