ALBERTA BLUE CROSS®

NUSINERSEN
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	COVERAGE TYPE ☐ Alberta Blue Cross ☐ Alberta Human Services ☐ 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
	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS	
CITY, PROVINCE	PHONE / FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

Diagnosis	**Please indicate if this patient is**
☐ 5q Spinal Muscular Atrophy (SMA) ☐ Other (specify) _____	☐ starting drug upon approval ……..... **complete section I** ☐ new to coverage but currently maintained on drug …...**complete section I and II** ☐ submitting renewal request ……..…..**complete section II**

Dosage and frequency requested	Treatment start date	Date of last dose

Section I: Please provide pre-treatment information for all INITIAL requests for treatment naive and treatment experienced patients

Confirmation of diagnosis

☐ Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote Date
Note: copy of the test report must be provided

Disease Onset and Duration

Please check which of the following applies (check ONE only)

☐ Pre-symptomatic with two or three copies of the Survival Motor Neuron 2 (SMN2) gene **Note: copy of the test report must be provided**

☐ Disease duration of less than six months, two copies of SMN2, and symptom onset after the first week after birth and on or before seven months of age **Note: copy of the test report must be provided**

☐ Under the age of 18 with symptom onset after six months of age, regardless of the ability to walk independently

Please respond to the following

1) Disease duration at treatment initiation _____

2) Age of onset of clinical signs and symptoms consistent with SMA _____

3) Were symptoms present at birth? ☐ Yes ☐ No

Ventilation status

Patient requires permanent invasive ventilation* at treatment initiation? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Age-Appropriate Motor function score – Provide at least one of the following PRE-TREATMENT scores

a) Hammersmith Infant Neurological Examination [HINE] Section 2 pre-treatment score _____ Date _____

b) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND] pre-treatment score _____ Date _____

c) Hammersmith Functional Motor Scale-Expanded [HFMSE] pre-treatment score _____ Date _____

Section II: Please complete the following for all RENEWAL requests and for INITIAL requests for treatment experienced patients

Age-Appropriate Motor function score – Provide at least one of the following CURRENT RESPONSE scores

a) Hammersmith Infant Neurological Examination [HINE] Section 2 response score _____ Date _____

b) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND] response score _____ Date _____

c) Hammersmith Functional Motor Scale-Expanded [HFMSE] response score _____ Date _____

Ventilation status

Patient currently requires permanent invasive ventilation*? ☐ Yes ☐ No

* defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	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