

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

PATIENT INFORMATION

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|---------------------------|--------------------------------|---------|---|
| PATIENT LAST NAME | FIRST NAME | INITIAL | COVERAGE TYPE <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"/> CARNA | <input type="checkbox"/> ADA+C |
| CITY, PROVINCE | | | <input type="checkbox"/> ACP | <input type="checkbox"/> Other |
| POSTAL CODE | | | PHONE | FAX |
| FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED | | | | |

Please provide the following information for ALL requests

| | | |
|---|---|-------------------|
| Diagnosis <input type="checkbox"/> 5q Spinal Muscular Atrophy (SMA) <input type="checkbox"/> Other (specify) _____ | Please indicate if this patient is <input type="checkbox"/> starting drug upon approval complete section I <input type="checkbox"/> new to coverage but currently maintained on drug complete section I and II <input type="checkbox"/> 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

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| Confirmation of diagnosis | |
| <input type="checkbox"/> 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) <input type="checkbox"/> Pre-symptomatic with two or three copies of the Survival Motor Neuron 2 (SMN2) gene Note: copy of the test report must be provided <input type="checkbox"/> 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 <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ventilation status | |
| Patient requires permanent invasive ventilation* at treatment initiation? <input type="checkbox"/> Yes <input type="checkbox"/> 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*? <input type="checkbox"/> Yes <input type="checkbox"/> 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 | | |

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.
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