

Please complete all required sections to allow your request to be processed.

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"/> CARNA	<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 INITIAL requests

1) Drug requested <input type="checkbox"/> VPRIV <input type="checkbox"/> Elelyso: if requesting Elelyso, please indicate the reasons that the patient is unable to receive therapy with velaglucerase alfa, including <input type="checkbox"/> Rare cases of severe allergic reactions or hypersensitivity to velaglucerase alfa, please elaborate on the nature of reaction* _____ <input type="checkbox"/> Patients who are sub-optimally responsive despite maximum doses of velaglucerase alfa for at least 12 months, please elaborate* _____ <input type="checkbox"/> Patients unable to receive velaglucerase alfa for medical reasons, please elaborate* _____ <i>*Supporting documentation may be required</i>	Please indicate if this patient is <input type="checkbox"/> starting drug upon approval <input type="checkbox"/> new to coverage but currently maintained on drug <input type="checkbox"/> submitting renewal request
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2a) Weight (kg)	2b) Dosage and frequency
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3) Diagnosis <input type="checkbox"/> Type 1 Gaucher Disease <input type="checkbox"/> Other (specify) _____
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4) Confirmation of Diagnosis	
<input type="checkbox"/> Specific deficiency of glucocerebrosidase in tissue or cultured skin fibroblasts.	Date
<input type="checkbox"/> Presence, in tissue or peripheral blood leukocytes, of mutations in the glucocerebrosidase gene known to result in severe enzyme deficiency.	Date
<input type="checkbox"/> Other potentially confounding diagnoses, such as Hodgkin's disease or other storage disorders must have been ruled out	Date:

Please provide the following information for ALL requests

5) Exclusion criteria (does patient meet any of the following?)	
The presence of any Gaucher disease-related condition that might reasonably be expected to compromise a response to therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
The presence of another medical condition that might reasonably be expected to compromise a response to therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asymptomatic Gaucher disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
The presence of primary neurological disease due to Gaucher disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

The information collected by this form is collected 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 purpose 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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6) Clinical Measures monitored for the patient:

Baseline parameters	Baseline Measures	Response measures for renewals and for patients already on drug but new to coverage
Hemoglobin	<85% of lower limit of age- and sex-appropriate normal <input type="checkbox"/> Yes <input type="checkbox"/> No	Hb level (g/L): _____ Date:
Platelet count	<50 x 10 ⁹ /L on two separate occasions at least one month apart <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increase platelet count to level sufficient to prevent spontaneous bleeding <input type="checkbox"/> Normalization of platelet count in splenectomized patients <input type="checkbox"/> In patients with intact spleen, an increase of at least 1.5X in baseline platelet count
Splenic infarction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spleen volume reduction: _____(%) <input type="checkbox"/> Prevention of further splenic infarcts <input type="checkbox"/> Evidence of splenic infarcts
Bone crises	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prevention of bone crises <input type="checkbox"/> Evidence of bone crises
Radiographic or MRI evidence of incipient destruction of any major joint at baseline	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Improvement in imaging parameters (either MRI, QCSI2, or BMD) <input type="checkbox"/> Evidence of further joint destruction
Spontaneous fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prevention of spontaneous fractures <input type="checkbox"/> Evidence of further fractures
Chronic bone pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Reduced bone pain <input type="checkbox"/> Increased bone pain
Major Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Optimize surgical outcome for major joint replacement surgery where required at baseline. <input type="checkbox"/> Need for new major joint replacement surgery where it was not required at baseline.
Liver synthetic dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Improvement in liver function <input type="checkbox"/> Decline in liver function
Symptomatic hepatosplenomegaly	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spleen volume reduction: _____(%) <input type="checkbox"/> Liver volume reduction: _____(%)
Progressive pulmonary disease due to Gaucher disease	Pulmonary hypertension (PH) <input type="checkbox"/> Yes <input type="checkbox"/> No Need for oxygenation <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatopulmonary syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> pulmonary hypertension (PH) <input type="checkbox"/> improvement <input type="checkbox"/> evidence of worsening PH <input type="checkbox"/> oxygenation <input type="checkbox"/> improvement <input type="checkbox"/> decrease <input type="checkbox"/> hepatopulmonary syndrome <input type="checkbox"/> reversal <input type="checkbox"/> continuation
Growth failure in children	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Return to normal range on height percentiles <input type="checkbox"/> less than normal range on height percentiles

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

