

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

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

PATIENT INFORMATION				COVERAGE TYPE
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			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION				
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
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	

Drug requested     Inotersen (e.g. Tegsedi)     Patisiran (e.g. Onpattro)

**Please provide the following information for ALL requests**

<b>Diagnosis</b> <input type="checkbox"/> Hereditary transthyretin amyloidosis polyneuropathy (hATTR-PN) <input type="checkbox"/> Other (specify) _____	<b>Please indicate if this patient is</b> <input type="checkbox"/> starting drug upon approval .....complete section I <input type="checkbox"/> new to coverage but currently maintained on drug .....complete section I & II <input type="checkbox"/> submitting renewal request ..... complete section II
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**Combination use**  
Please indicate if the patient will be using the requested drug in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR     Yes     No

**Section I: INITIAL requests for treatment naïve and treatment experienced patients**

**Does the patient have a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR)?**  
 Yes → please provide a copy of the genetic test report     No

**Please indicate if the following apply to this patient at treatment initiation (check all that apply):**

is symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II

does NOT exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)

has NOT previously undergone a liver transplant

**Section II: RENEWAL requests and INITIAL requests for treatment experienced patients**

Please indicate if the following currently apply to this patient (check Yes or No for a-c below):	Yes	No
a) shows continued benefit from treatment with the requested drug	<input type="checkbox"/>	<input type="checkbox"/>
b) is permanently bedridden and dependent on assistance for basic activities of daily living	<input type="checkbox"/>	<input type="checkbox"/>
c) is receiving end-of-life care	<input type="checkbox"/>	<input type="checkbox"/>

**Additional information relating to request**

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to <b>Alberta Blue Cross, Clinical Drug Services</b> <b>10009 108 Street NW, Edmonton, Alberta T5J 3C5</b> <b>FAX 780-498-8384</b> in Edmonton • <b>1-877-828-4106</b> toll free all other areas
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**ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE FAX YOUR REQUEST.**

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**Criteria for coverage****INOTERSEN (e.g. Tegsedi) special authorization criteria**

"For the treatment of polyneuropathy in adult patients with a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) in patients who meet the following criteria:

- Are symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II

And

- do not exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)

And

-have not previously undergone a liver transplant.

For coverage, this drug must be prescribed by a specialist with experience in the diagnosis and management of hATTR.

Initial coverage may be approved for 284 mg administered subcutaneously once weekly for a period of nine months. Patients will be limited to receiving a four-week supply of inotersen per prescription at their pharmacy.

For renewal of coverage, patients must show continued benefit from treatment with inotersen and must NOT be:

- permanently bedridden and dependent on assistance for basic activities of daily living, NOR  
- receiving end-of-life care.

Continued coverage may be approved for 284 mg weekly for a period of six months.

Coverage cannot be provided for use in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR."

**PATISIRAN (e.g. Onpattro) special authorization criteria**

"For the treatment of polyneuropathy in adult patients with a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) in patients who meet the following criteria:

-Patients are symptomatic with early-stage neuropathy, defined as polyneuropathy disability [PND] stage I to less than or equal to IIIB or familial amyloidotic polyneuropathy [FAP] stage I or II

And

- do not exhibit severe heart failure symptoms (defined as New York Heart Association [NYHA] class III or IV)

And

-have not previously undergone a liver transplant.

For coverage, this drug must be prescribed by a specialist with experience in the diagnosis and management of hATTR.

Initial coverage may be approved 30 mg administered intravenously once every three weeks for a period of nine months. Patients will be limited to receiving one dose of patisiran per prescription at their pharmacy.

For renewal of coverage, patients must show continued benefit from treatment with patisiran and must NOT be:

- permanently bedridden and dependent on assistance for basic activities of daily living, NOR  
- receiving end-of-life care.

Continued coverage may be approved for 30 mg every three weeks for a period of six months.

Coverage cannot be provided for use in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR."