ALBERTA BLUE CROSS®

COMBINATION CFTR MODULATORS SPECIAL AUTHORIZATION REQUEST FORM

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**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ 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			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate requested drug ☐ elexacaftor/tezacaftor/ivacaftor + ivacaftor (e.g. Trikafta) ☐ lumacaftor/ivacaftor (e.g. Orkambi)

Section I: Please provide the following information for ALL requests

Diagnosis ☐ Cystic Fibrosis (CF) ☐ Other (please specify) _____

Requested dosage and frequency

Please confirm if the patient is

1) currently receiving invasive mechanical ventilation via endotracheal tube or tracheostomy tube? ☐ Yes ☐ No

2) a previous recipient of a double lung transplant? ☐ Yes ☐ No

Section II: Please provide the following information for INITIAL requests for treatment naïve and treatment-experienced patients

Mutation affecting the Cystic Fibrosis Transmembrane conductance Regulator (CFTR) gene

☐ homozygous F508del ☐ heterozygous F508del ☐ Other (please specify) _____

Please provide the following pre-treatment information

1)	Number of days treated with oral and/or IV antibiotics for pulmonary exacerbations in the previous 6 months		
	And/or number of pulmonary exacerbations requiring oral and/or IV antibiotics in the previous 6 months		
2)	Number of CF related hospitalizations in the previous 6 months		
3)	Body Mass Index (BMI)		Date
4)	FEV1 % predicted – for patients aged 6 years and older		Date
5)	For lumacaftor/ivacaftor requests: Absolute decline in FEV1 % predicted within a 12 month period, sustained over at least 4 months, in spite of optimized medical therapies – for patients aged 6 years and older		

For lumacaftor/ivacaftor requests only: Do any of the following apply to the patient at pre-treatment? (check all that apply)

☐ Experienced one (1) or more pulmonary exacerbation(s) per year requiring IV antibiotics

☐ Experienced three (3) or more pulmonary exacerbations per year requiring therapy with oral antibiotics

Section III: Provide the following information for RENEWAL requests and for INITIAL requests for treatment-experienced patients

1)	Number of days treated with oral and/or IV antibiotics for pulmonary exacerbations in the previous 6 months		
	And/or number of pulmonary exacerbations requiring oral and/or IV antibiotics in the previous 6 months		
2)	Number of CF related hospitalizations in the previous 6 months		
3)	Current Body Mass Index (BMI)		Date
4)	Current FEV1 % predicted – for patients aged 6 years and older		Date

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

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST