ALBERTA BLUE CROSS®

# SIPONIMOD
## for Secondary Progressive Multiple Sclerosis (SPMS)
## SPECIAL AUTHORIZATION REQUEST FORM

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

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

| PATIENT INFORMATION | | | | COVERAGE TYPE |
|---|---|---|---|---|
| LAST NAME | FIRST NAME | | INITIAL | ☐ Alberta Blue Cross<br>☐ Alberta Human Services<br>☐ 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 | | | ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other<br>REGISTRATION NUMBER |
| CITY, PROVINCE | PHONE | | FAX |
| POSTAL CODE | FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED | | |

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

☐ **NEW request** – starting siponimod upon approval

☐ **NEW request** – new to coverage but currently maintained on siponimod

☐ **MS DMT SWITCH**

☐ **RENEWAL request**

**Diagnosis**

☐ Secondary progressive multiple sclerosis (SPMS)

☐ Other (specify) _____

**Dosage and frequency requested**

**For NEW requests for treatment naïve and treatment experienced patients**

**Please indicate if the following apply to this patient at treatment initiation (check Yes or No for 1 & 2 below)**

| | | |
|---|---|---|
| 1) History of relapsing-remitting multiple sclerosis (RRMS) and current active SPMS | ☐ Yes | ☐ No |
| 2) Documented Expanded Disability Status Scale (EDSS) progression during the two years prior to initiating treatment with siponimod (increase by 1 point or more if EDSS is less than 6.0; increase by 0.5 points or more if EDSS 6.0 or more at screening) | ☐ Yes | ☐ No |

**Please provide the following <u>pre-treatment</u> information**

**EDSS score** (at siponimod initiation) _____ . _____

**Date** _____

**Timed 25-foot walk (T25W) score** (at siponimod initiation) _____ (seconds)

**Date** _____

For patients already on siponimod, please specify start date (YYYY-MM-DD) _____

**For RENEWAL requests and NEW requests for treatment experienced patients**

**Please provide the following <u>current</u> information**

**Current EDSS** _____ . _____ **Date** _____

**Current T25W** _____ (seconds) **Date** _____

**Additional information relating to request**

| PRESCRIBER'S SIGNATURE | DATE (YYYY-MM-DD) | Please forward this request to<br>**Alberta Blue Cross, Clinical Drug Services**<br>**10009 108 Street NW, Edmonton, Alberta T5J 3C5**<br>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**