

**SOFOSBUVIR/VELPATASVIR  
FOR CHRONIC HEPATITIS C  
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
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			REGISTRATION NUMBER	
			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other	
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Note: Coverage of ribavirin in combination with the drug regimen will be approved according to criteria specified in the *Alberta Drug Benefit List*.

**1) Does the patient have a quantitative HCV RNA value within six months of this request?**  
 Yes → Provide test date (YYYY-MM-DD) \_\_\_\_\_       No       Not tested

**2) Does the patient have decompensated cirrhosis with Child-Turcotte-Pugh B or C (i.e. score seven or above)?**  
 Yes  
 No

**3) Has the patient previously been treated with an HCV antiviral drug regimen?**  
 No, the patient is treatment-naïve  
 Yes → Specify drug regimen previously used \_\_\_\_\_

**4) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) \_\_\_\_\_**

**5) Indicate the name of the specialist consulted, where applicable \_\_\_\_\_**

**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> FAX <b>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.**

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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