ALBERTA BLUE CROSS®

SOFOSBUVIR/LEDIPASVIR 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	☐ 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 REGISTRATION NUMBER ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	
STREET ADDRESS		
CITY, PROVINCE	PHONE	FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Note: Duration of therapy and 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 Hepatitis C Virus (HCV) Genotype 1? ☐ Yes ☐ No

2) 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**

3) Does the patient have cirrhosis?

☐ **Yes, compensated cirrhosis with Child-Turcotte-Pugh A** (i.e. score five to six)

☐ **Yes, decompensated cirrhosis with Child-Turcotte-Pugh B or C** (i.e. score seven or above)

☐ **No**

4) Is treatment requested post liver transplant? ☐ **Yes** ☐ **No**

5) Has the patient previously been treated with an HCV antiviral drug regimen?

☐ **No,** the patient is treatment-naïve

☐ **Yes** → Specify drug regimen previously used _____

6) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) _____

7) 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 **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.

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.