ALBERTA BLUE CROSS®

CLADRIBINE / FINGOLIMOD / NATALIZUMAB
For Multiple Sclerosis
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		
STREET ADDRESS	☐ CPSA ☐ CARNA ☐ ACP	☐ ACO ☐ ADA+C ☐ Other	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

Indicate which MS disease modifying therapy (DMT) is requested (check one box)

☐ **Gilenya** (fingolimod) ☐ **Mavenclad** (cladribine) → provide patient weight (kg) _____ ☐ **Tysabri** (natalizumab)

☐ **NEW request** (i.e. new to MS DMT and/or coverage) ☐ **RENEWAL request** ☐ **RESTART request** ☐ **MS DMT SWITCH**

For patients already on the requested MS DMT, specify start date (YYYY-MM-DD) _____

For patients already on cladribine, also specify the number of treatment courses and doses/course administered _____

Diagnosis

☐ Relapsing-remitting multiple sclerosis

☐ Other (please specify) _____

Current *EDSS _____. _____ Date_____

***If the current EDSS is 7.0 or above,** has the EDSS score been sustained at 7.0 or above for one year or more? ☐ Yes ☐ No

Please provide the following information for all NEW requests and for RESTART after treatment interruption

Qualifying relapses: Provide the dates of two relapses within the last two years OR the two years prior to starting MS DMT

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

a) Has the patient been on MS DMT of any kind since the relapse(s)? ☐ No ☐ Yes → **If yes, answer b) and c)**

b) Specify the MS DMT start date (YYYY-MM-DD) _____

c) Indicate if there have been any interruptions in therapy since starting MS DMT ☐ No ☐ Yes → **If yes, indicate**

i) Reason for the interruption in therapy _____

ii) Specify time period of interruption: **from** (YYYY-MM-DD) _____ **to** (YYYY-MM-DD) _____

iii) How many relapses did the patient experience while off therapy? _____

NEW and SWITCH requests: Provide response to ONE of the following MS DMT
DIMETHYL FUMARATE; GLATIRAMER ACETATE; INTERFERON BETA; OCRELIZUMAB; OFATUMUMAB; PEGINTERFERON BETA; TERIFLUNOMIDE

Name of MS DMT utilized _____ and date of treatment initiation (YYYY-MM-DD) _____

☐ **INTOLERANCE** despite the use of symptom management techniques; **OR** ☐ **REFRACTORY** → answer a) and b)

a) Does the patient have clinically significant titres of neutralizing antibodies to interferon beta? ☐ Yes ☐ No ☐ N/A

b) Within a consecutive 12-month period while on the MS DMT, did the patient experience at least two relapses of MS?

☐ No ☐ Yes → **Provide the dates of either 2 clinical relapses OR 1 clinical relapse and 1 MRI relapse**

Date of relapse (YYYY-MM-DD)	**Type of relapse** (One MRI relapse may substitute for one clinical relapse)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)
	☐ Moderate to very severe clinical relapse ☐ MRI relapse (new T2 lesion or definite gadolinium-enhancing T1 lesion)

Fingolimod or Natalizumab RENEWAL requests and NEW requests for patients already on drug, please provide the following information

a) Has the patient experienced **more than one** relapse event per year since starting treatment? ☐ Yes ☐ No

b) If yes and the patient experienced four or more relapses in the year prior to starting treatment, has the patient demonstrated a 50 per cent reduction in relapse events since starting treatment? ☐ Yes ☐ No

Please provide the following information for the first natalizumab RENEWAL request only

Natalizumab neutralizing antibody test result

☐ Negative for natalizumab antibodies ☐ Positive for natalizumab antibodies Date of the test _____

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.