ALBERTA BLUE CROSS®

DIMETHYL FUMARATE / GLATIRAMER ACETATE / INTERFERON BETA-1A / OCRELIZUMAB / OFATUMUMAB / PEGINTERFERON BETA-1A / TERIFLUNOMIDE for RRMS / INTERFERON BETA-1B for SPMS or RRMS

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 ☐ 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	

Please provide the following information for ALL requests

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

☐ **Aubagio** (teriflunomide)
☐ **Avonex PS/Pen** (interferon beta-1a)
☐ **Betaseron** (interferon beta-1b)
☐ **Glatect** (glatiramer acetate)
☐ **Kesimpta** (ofatumumab)
☐ **Ocrevus** (ocrelizumab)
☐ **Plegridy** (peginterferon beta-1a)
☐ **Rebif** (interferon beta-1a)
☐ **Tecfidera** (dimethyl fumarate)

☐ **NEW request** (i.e. 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) _____

Diagnosis
☐ Relapsing-remitting multiple sclerosis (RRMS)
☐ Secondary-progressive multiple sclerosis (SPMS) with relapses
☐ 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 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? _____

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