

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

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

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

Drug requested (check ONE box)

Fulphila (pegfilgrastim) → complete Section I only
 Nyvepria (pegfilgrastim) → complete Section I only
 Grastofil (filgrastim) → complete Section I or II
 Plerixafor (e.g. Mozobil) → complete Section III only
 Lapelga (pegfilgrastim) → complete Section I only
 Ziextenzo (pegfilgrastim) → complete Section I only
 Nivestym (filgrastim) → complete Section I or II

Section I (Filgrastim requests for the first criterion and all pegfilgrastim requests, check ALL that apply)

a) Please **SPECIFY** the type of cancer being treated with chemotherapy for curative intent _____

b) Please provide the indication for which the drug is requested

patient has febrile neutropenia
 patient had febrile neutropenia from a previous cycle of the same chemotherapy
 patient will be undergoing a *high dose* or *aggressive* chemotherapy where febrile neutropenia is very likely to occur
 other (please **SPECIFY**) _____

Section II (Filgrastim requests for other criteria, check ALL that apply)

a) Please provide the indication for which filgrastim is requested

patient has neutropenia AND a diagnosis of
 congenital, cyclic or idiopathic neutropenia OR
 acute myeloid leukemia
 other, please **SPECIFY** _____

Section III (Plerixafor requests, check ALL that apply)

a) Please provide the patient's current weight (kg) _____

b) Please **SPECIFY** the type of cancer being treated

multiple myeloma (MM)
 Non-Hodgkin's Lymphoma (NHL)
 other, please **SPECIFY** _____

c) Please provide the indication for which the drug is requested

patient is undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy
 other (please **SPECIFY**) _____

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
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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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Criteria for coveragePatients may or may not meet eligibility requirements as established
by Alberta government-sponsored drug programs.**FILGRASTIM (e.g. Grastofil, Nivestym) special authorization criteria**

"In patients with non-myeloid malignancies, receiving myelosuppressive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia."

"Following induction and consolidation treatment for acute myeloid leukemia, for the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization."

"In patients with a diagnosis of congenital, cyclic or idiopathic neutropenia, to increase neutrophil counts and to reduce the incidence and duration of infection."

Please note for the first criterion: coverage cannot be considered for palliative patients.

PEGFILGRASTIM (e.g. Fulphila, Lapelga, Nyvepria, Ziextenzo) special authorization criteria

"In patients with non-myeloid malignancies, receiving myelosuppressive anti-neoplastic drugs with curative intent, to decrease the incidence of infection, as manifested by febrile neutropenia."

Please note: coverage cannot be considered for palliative patients.

PLERIXAFOR (e.g. Mozobil) special authorization criteria

"For the treatment of patients with Non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM) undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy, in combination with filgrastim, when prescribed by a designated prescriber."

Coverage may be approved for a maximum of four doses (0.24mg/kg given daily) for a single mobilization attempt.

Special authorization may be granted for 12 months.