

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.

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PATIENT INFORMATION

Patient last name	First name	Initial	Gender M / F	Birth date YYYY MM DD	Alberta Personal Health Number
Street address		City		Province	Postal code
ID/client/coverage number	Coverage type <input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other _____				

METABOLIC SPECIALIST INFORMATION

Last name	First name	Initial
Street address		Postal code
City		Province
Telephone number	Fax number	College of Physicians and Surgeons registration number
Date form completed (YYYY-MM-DD)	Last consult date (YYYY-MM-DD)	Metabolic Specialist signature

PHARMACY INFORMATION

Pharmacy name	Telephone number	Fax number
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INFORMATION REQUIRED

For **INITIAL COVERAGE (new to drug)**, please complete applicable sections of all pages, and submit together with the consent form.

For **CONTINUED COVERAGE (on drug now or prior use of drug)**, please complete page 1 and the response to therapy section on page 4.

For first requests for patients currently/previously on the drug, please complete all pages and submit together with the consent form.

Note: Additional pages may be attached as required; please submit the request form and attachments together.

TREATMENT REQUESTED

Dosage and frequency requested

DIAGNOSIS

<input type="checkbox"/> Hypophosphatasia (HPP)	
→ Specify type	<input type="checkbox"/> Antenatal <input type="checkbox"/> Newborn <input type="checkbox"/> Infantile <input type="checkbox"/> Juvenile (Childhood) <input type="checkbox"/> Adult
→ Specify age at onset and nature of first symptom	_____
<input type="checkbox"/> Other, specify _____	

CONFIRMATION OF DIAGNOSIS

Does the patient have perinatal/infantile or juvenile-onset HPP confirmed by	Yes	No	Details (attach laboratory reports)
a) Genetic testing (documented tissue-nonspecific alkaline phosphatase [TNSALP] gene mutation(s))?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Serum alkaline phosphatase (ALP) level below the age-adjusted normal range?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Plasma pyridoxal-5-phosphate (PLP) above the upper limit of normal established and validated in testing laboratory?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Documented history of HPP-related skeletal abnormalities confirmed radiologically?	<input type="checkbox"/>	<input type="checkbox"/>	

FOR TREATMENT EXPERIENCED PATIENTS

1) Patient is currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No → specify stop date and reason	
2) Indicate initial therapy start date	3) Patient started therapy prior to 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please mail this request to	Or fax to	Case number
<input type="checkbox"/> Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta T5J 3C5	<input type="checkbox"/> 780-401-1150 in Edmonton <input type="checkbox"/> 1-888-401-1150 toll free all other areas	

Patient's Alberta Personal
Health Number (only)

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ADDITIONAL CLINICAL CRITERIA (continued)

System	Details (Check ALL that apply and attach relevant reports)
4) Pain	<input type="checkbox"/> Muscle pain <input type="checkbox"/> Bone pain <input type="checkbox"/> Joint pain Type of pain, location, pain at rest or with activity, daytime or at night <hr/> Interventions <input type="checkbox"/> Analgesics, specify drug(s) and dose _____ <input type="checkbox"/> Heating pad <input type="checkbox"/> Massage <input type="checkbox"/> Other, specify _____ Response to previous interventions <hr/> <input type="checkbox"/> Visual analog for pain report attached Comments
5) X-ray findings	<input type="checkbox"/> Skeletal survey, specify age at X-rays, X-ray findings, and most recent X-ray results <hr/> <input type="checkbox"/> X-ray report attached
6) Renal	<input type="checkbox"/> Nephrocalcinosis <input type="checkbox"/> Renal failure/reduced renal function <input type="checkbox"/> Lab report attached Comments
7) Respiratory	<input type="checkbox"/> Lung hypoplasia <input type="checkbox"/> Decreased thoracic volume <input type="checkbox"/> Respiratory failure <input type="checkbox"/> Supplemental O2 required <input type="checkbox"/> Assisted ventilation Comments
8) Biochemical	<input type="checkbox"/> Lab reports attached for calcium, phosphate, magnesium, alkaline phosphatase (ALP), PTH, 25 OH vitamin D, pyridoxal-5-phosphate (PLP), urine phosphoethanolamine (PEA)
9) Other	<input type="checkbox"/> Hearing Loss, specify _____ <input type="checkbox"/> Seizures → B6 responsive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Delayed cognitive development, specify _____ Comments
Additional information relating to request	

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Case number

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MONITORING AND GOALS OF THERAPY

1) Signs and symptoms to be monitored depend on age at diagnosis and may include, in addition to the parameters listed in the "Additional Clinical Criteria" table on page 2 of this form:

For perinatal/infantile HPP: Discontinuation or reduction of ventilatory support, increased mobility (improvement in gait vs. baseline), attainment of age-appropriate gross motor milestones.

For juvenile HPP: Healing of rickets, improvement of bone mineralization and/bony deformities, fewer fractures, less pain, need for less pain medication, improved growth, increased mobility.

Please indicate which clinical, radiological and biochemical parameters and goals of therapy will be monitored for this patient:

2) Documented compliance by patient and family with respect to follow up visits and re-evaluation of laboratory and radiological parameters.

RESPONSE TO THERAPY (update for each request for continuation of therapy, attach additional pages as required)

1) Were the pre-specified goals of therapy met? (include documented signs/symptoms noted above)

2) Were the patient and family compliant with respect to follow up visits and re-evaluation of laboratory and radiological parameters?

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