

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 <input type="checkbox"/> ACP <input type="checkbox"/> Other
			PHONE
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

<input type="checkbox"/> NEW request for patient starting ocrelizumab upon approval <input type="checkbox"/> NEW request for patient currently maintained on ocrelizumab (i.e. new to coverage) <input type="checkbox"/> RENEWAL request <input type="checkbox"/> RESTART request
Diagnosis <input type="checkbox"/> Primary progressive multiple sclerosis (PPMS) → Diagnosis meets 2017 McDonald criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain _____ <input type="checkbox"/> Other (specify) _____
Current EDSS _____ Date _____

Please provide the following information for NEW requests for patients new to ocrelizumab or to coverage

EDSS prior to ocrelizumab initiation _____ Date _____
Functional Systems Scale score for the pyramidal system due to lower extremity findings (at ocrelizumab initiation) _____ Date _____
Are there documented imaging features characteristic of inflammatory activity? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain _____
Disease duration (at ocrelizumab initiation) _____
If patient is already on ocrelizumab, specify date started (YYYY-MM-DD) _____

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

