ALBERTA BLUE CROSS®

ALEMTUZUMAB
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 ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for ALL requests

☐ **NEW request** (i.e. new to MS DMT and/or coverage) ☐ **MS disease modifying therapy (DMT) SWITCH**

For patients new to coverage and already on alemtuzumab, specify start date (YYYY-MM-DD) _____ and number of treatment courses and doses/course administered _____

Diagnosis ☐ Relapsing-remitting multiple sclerosis
☐ Other (specify) _____

Current EDSS _____. _____ Date (YYYY-MM-DD) _____

NEW requests: 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? _____

ALL requests: Provide response to <u>TWO</u> of the following MS DMT: CLADRIBINE; DIMETHYL FUMARATE; FINGOLIMOD; GLATIRAMER ACETATE; INTERFERON BETA; NATALIZUMAB; OCRELIZUMAB; OFATUMUMAB; PEGINTERFERON BETA; TERIFLUNOMIDE

Name of <u>1st</u> 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 two clinical relapses OR one clinical relapse and one 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)

Name of <u>2nd</u> 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 two clinical relapses OR one clinical relapse and one 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)

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.