

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

**Please provide the following information for ALL requests**

<b>Requested Drug</b>	<input type="checkbox"/> Edaravone (e.g. Radicava)	<input type="checkbox"/> Sodium Phenylbutyrate/Ursodoxicoltaurine (e.g. Albrioza)
<b>Diagnosis</b>	<b>Please indicate if this patient is</b>	
<input type="checkbox"/> Amyotrophic lateral sclerosis (ALS)	<input type="checkbox"/> starting drug upon approval ..... <b>complete section I.</b>	
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> new to coverage but currently maintained on drug ... <b>complete section I and II.</b>	
	<input type="checkbox"/> submitting renewal request ..... <b>complete section II.</b>	
Dosage and frequency requested	Treatment start date	Date of last dose

**Section I: Provide pre-treatment information for all INITIAL requests for treatment naive and treatment experienced patients**

<b>Disease onset and duration</b>		
<b>For Radicava only</b> , has the patient had ALS symptoms for 2 years or less <i>prior</i> to initiation of the requested drug?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>For Albrioza only</b> , has the patient had ALS symptoms for 18 months or less <i>prior</i> to initiation of the requested drug?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient require permanent non-invasive or invasive ventilation at treatment initiation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>PRE-TREATMENT scores</b>		
a) Pre-treatment Forced Vital Capacity (FVC) _____	Date _____	
<b>For Radicava only</b>		
b) Pre-treatment ALS Functional Rating Scale – Revised (ALSFRS-R) _____	Date _____	
c) Does the patient have <b>scores of at least two (2) points on each item</b> of the ALSFRS-R provided in b)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>For Albrioza only</b>		
a) Is the patient <b>non-ambulatory</b> (ALSFRS-R score of less than or equal to 1 for item 8)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Is the patient <b>unable</b> to cut food and feed themselves without assistance, irrespective of whether a gastrostomy is in place (ALSFRS-R score less than 1 for item 5a or 5b)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Section II: Please complete the following for all RENEWAL requests and for INITIAL requests for treatment experienced patients**

<b>CURRENT RESPONSE scores</b>		
a) For Radicava only, current ALS Functional Rating Scale – Revised (ALSFRS-R) _____	Date _____	
b) Is the patient <b>non-ambulatory</b> (ALSFRS-R score of less than or equal to 1 for item 8)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Is the patient <b>unable</b> to cut food and feed themselves without assistance, irrespective of whether a gastrostomy is in place (ALSFRS-R score less than 1 for item 5a or 5b)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient currently require permanent non-invasive or invasive ventilation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Additional Information relating to request**

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to ▪ <b>Alberta Blue Cross, Clinical Drug Services</b> 10009 108 Street NW, Edmonton, Alberta T5J 3C5 ▪ <b>FAX: 780-498-8384</b> in Edmonton • <b>1-877-828-4106</b> toll free all other areas
------------------------	-------------------	---

**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.  
 ©The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan. ©† Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association. 60080 (2023/07)

