ALBERTA BLUE CROSS®

EDARAVONE/ SODIUM PHENYLBUTYRATE/URSODOXICOLTAURINE 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 ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
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

Requested Drug ☐ Edaravone (e.g. Radicava) ☐ Sodium Phenylbutyrate/Ursodoxicoltaurine (e.g. Albrioza)

Diagnosis	**Please indicate if this patient is**	
☐ Amyotrophic lateral sclerosis (ALS) ☐ Other (specify) _____	☐ starting drug upon approval ……..**complete section I.** ☐ new to coverage but currently maintained on drug …**complete section I and II.** ☐ submitting renewal request ……..……**complete section II.**	
Dosage and frequency requested	Treatment start date	Date of last dose

Section I: Provide <u>pre-treatment</u> information for all INITIAL requests for treatment naive and treatment experienced patients

Disease onset and duration		
For Radicava only, has the patient had ALS symptoms for 2 years or less *prior* to initiation of the requested drug?	☐ Yes	☐ No
For Albrioza only, has the patient had ALS symptoms for 18 months or less *prior* to initiation of the requested drug?	☐ Yes	☐ No
Does the patient require permanent non-invasive or invasive ventilation at treatment initiation?	☐ Yes	☐ No
PRE-TREATMENT scores		
a) Pre-treatment Forced Vital Capacity (FVC) _____ Date _____		
For Radicava only		
b) Pre-treatment ALS Functional Rating Scale – Revised (ALSFRS-R) _____ Date _____		
c) Does the patient have **scores of at least two (2) points on each item** of the ALSFRS-R provided in b)?	☐ Yes	☐ No
For Albrioza only		
a) Is the patient **non-ambulatory** (ALSFRS-R score of less than or equal to 1 for item 8)?	☐ Yes	☐ No
b) Is the patient **unable** 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)?	☐ Yes	☐ No

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

CURRENT RESPONSE scores		
a) For Radicava only, current ALS Functional Rating Scale – Revised (ALSFRS-R) _____ Date _____		
b) Is the patient **non-ambulatory** (ALSFRS-R score of less than or equal to 1 for item 8)?	☐ Yes	☐ No
c) Is the patient **unable** 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)?	☐ Yes	☐ No
Does the patient currently require permanent non-invasive or invasive ventilation?	☐ Yes	☐ No
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

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST