ALBERTA BLUE CROSS®

COMBINATION CFTR MODULATORS SPECIAL AUTHORIZATION REQUEST FORM

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	☐ 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

Indicate requested drug ☐ elexacaftor/tezacaftor/ivacaftor + ivacaftor (e.g. Trikafta) ☐ lumacaftor/ivacaftor (e.g. Orkambi)

Section I: Please provide the following information for ALL requests

Diagnosis ☐ Cystic Fibrosis (CF) ☐ Other (please specify) _____

Requested dosage and frequency

Please confirm if the patient is 1) currently receiving invasive mechanical ventilation via endotracheal tube or tracheostomy tube? ☐ Yes ☐ No
2) a previous recipient of a double lung transplant? ☐ Yes ☐ No

Section II: Please provide the following information for INITIAL requests for treatment naïve and treatment-experienced patients

Mutation affecting the Cystic Fibrosis Transmembrane conductance Regulator (CFTR) gene
☐ homozygous F508del ☐ heterozygous F508del ☐ Other (please specify) _____

Please provide the following pre-treatment information

1)	Number of days treated with oral and/or IV antibiotics for pulmonary exacerbations in the previous 6 months		
	And/or number of pulmonary exacerbations requiring oral and/or IV antibiotics in the previous 6 months		
2)	Number of CF related hospitalizations in the previous 6 months		
3)	Body Mass Index (BMI)		Date
	Or Body Mass Index (BMI) z-score for children		Date
4)	FEV1 % predicted – for patients aged 6 years and older		Date
5)	For lumacaftor/ivacaftor requests: Absolute decline in FEV1 % predicted within a 12 month period, sustained over at least 4 months, in spite of optimized medical therapies – for patients aged 6 years and older		

For lumacaftor/ivacaftor requests only: Do any of the following apply to the patient at pre-treatment? (check all that apply)
☐ Experienced one (1) or more pulmonary exacerbation(s) per year requiring IV antibiotics
☐ Experienced three (3) or more pulmonary exacerbations per year requiring therapy with oral antibiotics

Section III: Provide the following information for RENEWAL requests and for INITIAL requests for treatment-experienced patients

1)	Number of days treated with oral and/or IV antibiotics for pulmonary exacerbations in the previous 6 months		
	And/or number of pulmonary exacerbations requiring oral and/or IV antibiotics in the previous 6 months		
2)	Number of CF related hospitalizations in the previous 6 months		
3)	Current Body Mass Index (BMI)		Date
	Or current Body Mass Index (BMI) z-score for children		Date
4)	Current FEV1 % predicted – for patients aged 6 years and older		Date

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	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