

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	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
POSTAL CODE			PHONE	FAX	
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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

