

SIPONIMOD

for Secondary Progressive Multiple Sclerosis (SPMS) 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					COVERA	AGE TYPE		
LAST NAME	FIRST NAME INITIAL					rta Blue Cross		
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			Alberta Human Services				
ADDRESS	CITY PROV POSTAL CODE			D/CLIENT/COVERAGE NUMBER				
ADDRESS	CITT	PROV	FU31	AL CODE	ID/CLIEN	NI/COVERAGE NO	IVIDER	
PRESCRIBER INFORMATION								
PRESCRIBER LAST NAME FIRST NAME INITIAL			PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION CPSA CLACO REGISTRATION NUMBER					
ADDRESS			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other					
CITY, PROVINCE			PHONE FAX					
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED					
Please provide the following informati	on for ALL request	s						
☐ NEW request – starting siponimod upon approval			☐ MS DMT SWITCH					
☐ NEW request – new to coverage but currently maintained on s			siponimod RENEWAL request					
Diagnosis				Dosage and frequency requested				
☐ Secondary progressive multiple sclero								
☐ Other (specify)								
For NEW requests for treatment naïve	and treatment expe	erienced p	atient	ts				
Please indicate if the following apply t	o this patient at tre	atment init	iatio	ı (check Y	es or No	o for 1 & 2 belo	w)	
1) History of relapsing-remitting multiple sclerosis (RRMS) and cur			ctive	SPMS		☐ Yes	□ No	
2) Documented Expanded Disability Status Scale (EDSS) progres to initiating treatment with siponimod (increase by 1 point or m increase by 0.5 points or more if EDSS 6.0 or more at screening			ssion during the two years prior				□ No	
Please provide the following pre-treatment information								
EDSS score (at siponimod initiation) Timed 25-foo Date			T25V	V) score (a	t siponim	od initiation)	(seconds)	
For patients already on siponimod, please specify start date (YYYY-MM-DD)								
For RENEWAL requests and NEW requ	uests for treatment	experienc	ed pa	itients				
Please provide the following current in	nformation							
Current EDSS Date (Γ25W	1	(second	ds) Date		
Additional information relating to requ	est							
	DATE (YYYY-MM-DD)	Alberta BI 10009 108 FAX 780 -	ease 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 SU	(OLOHESISHEULE BY TIRVANISIM			INDIAM TOTAL	JK REEFA	X MAY CONTRACT TO THE STORY		

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.