

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 REGISTRATION NUMBER
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other
CITY, PROVINCE		PHONE	FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Note: Duration of therapy and coverage of ribavirin in combination with the drug regimen will be approved according to criteria specified in the *Alberta Drug Benefit List*.

1) Does the patient have Hepatitis C Virus (HCV) Genotype 1? Yes No

2) Does the patient have a quantitative HCV RNA value within six months of this request?
 Yes → Provide test date (YYYY-MM-DD) _____ No Not tested

3) Does the patient have cirrhosis?
 Yes, compensated cirrhosis with Child-Turcotte-Pugh A (i.e. score five to six)
 Yes, decompensated cirrhosis with Child-Turcotte-Pugh B or C (i.e. score seven or above)
 No

4) Is treatment requested post liver transplant? Yes No

5) Has the patient previously been treated with an HCV antiviral drug regimen?
 No, the patient is treatment-naïve
 Yes → Specify drug regimen previously used _____

6) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) _____

7) Indicate the name of the specialist consulted, where applicable _____

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

