

GLECAPREVIR/PIBRENTASVIR FOR CHRONIC HEPATITIS C 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 | GE TYPE | |
|---|--------------------------------|-----------|------------------------------------|---|--|---------------------------|--------------------------------------|--|
| PATIENT LAST NAME | FIRST NAME | | | II. | | ☐ Alberta Blue Cross | | |
| | | | | | | ☐ Alber | ta Human Services | |
| BIRTH DATE (YYYY-MM-DD) | ALBERTA PERSONAL HEALTH NUMBER | | | | | ☐ Other | | |
| | ALBERTA E LOGIAL HEALTH HOMBER | | | | | | | |
| | | | | | | | | |
| STREET ADDRESS | CITY | PRO | | / POSTAL C | | ID/CLIENT/COVERAGE NUMBER | | |
| | | | | | | | | |
| PRESCRIBER INFORMATION | | | | | | | | |
| PRESCRIBER LAST NAME FIRST NAME INITIAL | | | | PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION | | | | |
| | | | | REGISTRATION NUMBER | | | | |
| | | | | ☐ CPSA ☐ ACO | | | | |
| STREET ADDRESS | | | | ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other | | | | |
| | | | | | | | | |
| CITY, PROVINCE | | | PHONE | | | | FAX | |
| | | | | | | | | |
| DOOTAL OODS | | | | | | | | |
| POSTAL CODE | | | | FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED | | | | |
| | | | | | | | | |
| Note: Duration of therapy will be approved according to criteria specified in the Alberta Drug Benefit List. | | | | | | | | |
| 1) 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 | | | | | | | | |
| 2) Has the patient previously been treated with an HCV antiviral drug regimen? | | | | | | | | |
| □ No , the patient is treatment-naïve | | | | | | | | |
| → Does the patient have decompensated cirrhosis with Child-Turcotte-Pugh B or C (i.e. score seven or above)? | | | | | | | | |
| Yes | | | | | | | | |
| □ No | | | | | | | | |
| ☐ Yes → Specify drug regimen previously used | | | | | | | | |
| → Specify the patient's Genotype | | | | | | | | |
| → 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 | | | | | | | | |
| 3) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) | | | | | | | | |
| 4) Indicate the name of the specialist consulted, where applicable | | | | | | | | |
| Additional information relating to request | | | | | | | | |
| PRESCRIBER'S SIGNATURE DA | ΓΕ (YYYY-MM-DD) Ple | ase forwa | ırd this re | equest to | | | | |
| | , | Alberta B | 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 | | | | | | | 7-828-4106 toll free all other areas | |
| ONCE YOUR REQUEST HAS | | | | | | | | |

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 toil-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10099 108 Street, Edmonton AB T5J 3C5.

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