ALBERTA BLUE CROSS®

RIFAXIMIN
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
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage

"For reducing the risk of recurrent Hepatic Encephalopathy (HE) (i.e. 2 or more episodes), in patients with a diagnosis of cirrhosis of the liver or presence of portal hypertension.
Patients must have tried lactulose and been unable to achieve adequate control of HE recurrence with lactulose alone.
Rifaximin must be used in combination with a maximal tolerated dose of lactulose.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

Please provide the following information for all requests

Indication for use (check all that apply)

☐ To reduce the risk of recurrent Hepatic Encephalopathy (HE)

→ ☐ Patient has had 2 or more episodes of HE

☐ Other, specify _____

Previous therapy

Please indicate if lactulose was tried

☐ Yes → please indicate response to lactulose ☐ unable to achieve adequate control of HE recurrence

☐ other, specify _____

☐ No, specify reason _____

Concomitant therapy

Please indicate if rifaximin will be used in combination with a maximal tolerated dose of lactulose

☐ Yes

☐ No, specify reason _____

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

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

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.