

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		
			<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	REGISTRATION NUMBER	
STREET ADDRESS			PHONE	FAX	
CITY, PROVINCE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
POSTAL CODE					

**Please provide the following information for ALL requests**

<b>Diagnosis</b>	<input type="checkbox"/> Mucopolysaccharidosis type IVA (MPS IVA)	<b>Current weight (kg)</b>
	→ confirmed by enzymatic assay for N-acetylgalactosamine-6-sulfate sulfatase (GALNS) activity in peripheral blood leukocytes or fibroblasts (excluding multiple sulfatase deficiency)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	→ confirmed by mutation analysis of GALNS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other (specify) _____		

**Dosage and frequency**

**Do any of the following apply to the patient? (exclusion criteria)**

	Yes	No
Diagnosed with an additional progressive life limiting condition where treatment would not provide long term benefit	<input type="checkbox"/>	<input type="checkbox"/>
Has a forced vital capacity (FVC) of less than 0.3 litres and requires continuous ventilator assistance	<input type="checkbox"/>	<input type="checkbox"/>
The patient/family is unwilling to comply with the associated monitoring criteria	<input type="checkbox"/>	<input type="checkbox"/>
The patient/family is unwilling to attend clinics for assessment and treatment purposes	<input type="checkbox"/>	<input type="checkbox"/>

**Please provide the following information for INITIAL requests for treatment naïve and treatment-experienced patients**

Please provide the following **pre-treatment** information

1)	6 Minute Walking Test (6MWT) (m)	Date	
	Stair Climb Test (SCT)	Date	
2)	Forced Vital Capacity (FVC) (% predicted); OR	Date	
	Forced expiratory volume in 1 second (FEV1) (% predicted)	Date	
3)	Urine keratin sulfate (KS) (mg/mmol creatinine)	Date	
4)	Ejection fraction (%)	Date	
5)	Baseline evaluation of age-appropriate quality of life measure (e.g. HAQ, PODCI, EQ5D5L, or SF36):	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Please provide the following information for all RENEWAL requests and for INITIAL requests for treatment-experienced patients**

**Has the patient demonstrated the following while on elosulfase alfa therapy?**

	Yes	No
Unable to tolerate infusions due to infusion related adverse events that cannot be resolved	<input type="checkbox"/>	<input type="checkbox"/>
Requires continuous respiratory support	<input type="checkbox"/>	<input type="checkbox"/>
Has missed more than 6 infusions in a 12-month interval, unless for medically related issues	<input type="checkbox"/>	<input type="checkbox"/>

Please provide the following **current** information

1)	6 Minute Walking Test (6MWT) (m)	Date	
	Stair Climb Test (SCT)	Date	
2)	Forced Vital Capacity (FVC) (% predicted); OR	Date	
	Forced expiratory volume in 1 second (FEV1) (% predicted)	Date	
3)	Urine keratin sulfate (KS) (mg/mmol creatinine)	Date	
4)	Ejection fraction (%)	Date	
5)	Improvement or no change (if minimal effect) in age-appropriate quality of life measure (e.g. HAQ, PODCI, EQ5D5L, or SF36):	Yes <input type="checkbox"/>	No <input type="checkbox"/>

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to <b>Alberta Blue Cross, Clinical Drug Services</b> <b>10009 108 Street NW, Edmonton, Alberta T5J 3C5</b> <b>FAX 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas</b>
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**ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.**