ALBERTA BLUE CROSS®

MARIBAVIR
SPECIAL AUTHORIZATION REQUEST FORM

Please complete ALL 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	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ 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	
STREET ADDRESS	☐ CPSA ☐ CARNA ☐ ACP ☐ ACO ☐ ADA+C ☐ Other	REGISTRATION NUMBER
CITY , PROVINCE	PHONE	FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Criteria for Coverage

For the treatment of adult patients with post-transplant cytomegalovirus (CMV) infection/disease who are refractory* (with or without genotypic resistance) to 1 or more of the following antiviral drugs: valganciclovir, ganciclovir, foscarnet, or cidofovir.

Special authorization may be granted for 6 months.

Subsequent treatment with maribavir may be reimbursed for patients who have a recurrence of CMV viremia after a previous successful course of therapy with maribavir.

Treatment should be discontinued if any of the following occur:

- no change or an increase in CMV viral load after at least 2 weeks of maribavir treatment OR
- confirmed CMV genetic mutation associated with resistance to maribavir.

*Refractory to antiviral treatment is defined as: a lack of change in CMV viral load or increase in CMV viral load after at least 2 weeks of appropriately dosed treatment.

For coverage, this drug must be prescribed by or/in consultation with a Specialist in Transplant Medicine, Transplant Infectious Disease, Internal Medicine, or Infectious Diseases.

Please provide the following information for all NEW requests

Indication for use

☐ Treatment of post-transplant CMV infection/disease

☐ Other, specify _____

Previous therapy

Please indicate if the patient is refractory* to 1 or more of the following antiviral drugs: valganciclovir, ganciclovir, foscarnet, or cidofovir

☐ Yes

☐ No, specify reason _____

Please indicate the name of the specialist consulted, where applicable _____

Please provide the following information for SUBSEQUENT TREATMENT requests

Patient has a recurrence of CMV viremia after a previous successful course of therapy with maribavir? ☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	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