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Phone: 1-877-431-4786
www.asebp.ca

ENHANCED SPECIAL AUTHORIZATION REQUEST: Chronic Hepatitis C

INSTRUCTIONS:

1. **Please note that this form is to only be used by ASEBP covered members and their dependants. Members of the ARTA Retiree Benefits Plan do not need to use this form.**
2. Please complete "Part 1: Patient Information", then have your physician, who must be a specialist in the area of treatment, complete "Part 2: Clinical Information" and submit it to ASEBP on your behalf by fax at 888-895-6837 or by email at SpecAuthHS@asebp.ca.
3. Please be aware that as the covered member, you are responsible for any fees charged by your physician/specialist for the completion of this form. Form fees for enhanced special authorization requests are not covered by your plan.
4. If you or your physician have any questions about the enhanced special authorization process, please contact our ASEBP Specialty Claims Coordinator at 780-431-4780.

Part 1: Patient Information *(to be completed by patient)*

A. Patient Information

Last name:	First name:	ASEBP ID:
Address:	Date of birth (YYYY/MM/DD):	
City:	Province:	Postal code:
School jurisdiction (if patient is the covered member):	If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: ❑ Spouse ❑ Dependant	

NOTE: Important notifications will ***only*** be sent to the covered member email address used to register with My ASEBP. To register, visit www.asebp.ab.ca/MyASEBP/ and follow the prompts.

Coordination of Benefits

Do you or your dependants have prescription drug coverage through another health benefits company, insurance company or another ASEBP plan? ❑ Yes ❑ No

If yes, please complete below.

Name of other health benefits company or insurance company:	Name of person holding coverage:
Effective date of other coverage (YYYY/MM/DD):	Coverage holder date of birth (YYYY/MM/DD):

Have you previously applied for funding or support from the manufacturer/patient assistance program for this medication?

☐ Yes ☐ No

Please provide details and attach documentation of approval or declination:

The manufacturer/patient assistance program may have information which will be useful for your enhanced special authorization request, such as the verification of health and claims information related to your request. May ASEBP contact the manufacturer/patient assistance program to discuss or collect information related to your enhanced special authorization request?

☐ Yes ☐ No

B. Consent to Collection, Use and Disclosure of Personal Health Information

The personal information contained in this form (with any supporting documentation provided) and other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility for this benefit, to provide you with information regarding additional resources available to you through your benefits (e.g., Employee Family Assistance Program, Apple-a-Day) and administer the benefit plan. It may be necessary for ASEBP to disclose your personal information related to this notification to a third party service provider. When third party service providers are retained, appropriate contracts are in place to protect personal information.

I authorize my prescribing physician, pharmacist and/or the manufacturer/patient assistance program (if 'yes' was selected in the applicable area of the Coordination of Benefits section above) to disclose to ASEBP the information noted herein and any further information requested by ASEBP for the purpose of managing this enhanced special authorization request.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my/our eligibility to receive benefits related to this special authorization request.

I agree this authorization shall be in effect from the date below and shall be valid for the duration of time required to manage this request.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

I agree to the above and declare that my statements in this form are complete, accurate and true.

VERBAL CONSENT WILL NOT BE ACCEPTED, FORM MUST BE SIGNED BY PATIENT OR PARENT/GUARDIAN.

Patient signature: _____ Date: _____

If patient is a minor, parent/guardian signature: _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta, Schedule 1 of the federal Personal Information Protection Electronic Documents Act and, in relation to personal health information, section 34 of the Health Information Act of Alberta. If you have any questions regarding the collection, use or disclosure of your personal information, please refer to our website at www.asebp.ca or contact the Privacy Officer at po@asebp.ca or 780-438-5300.

Part 2: Clinical Information *(to be completed by **prescribing physician**; must be a specialist in area of treatment)*

A. Prescriber Information

Prescriber name:		CPSA #:	
Address:		Specialty:	
City:	Province:	Phone:	Fax: *Fax number must be provided with each request submitted.*
Postal code:			

B. Medication Requested

Drug name requested:	Is the patient currently on this medication? ☐ Yes; start date: _____ ☐ No
Drug strength(s): Please specify if titration is required and drug strengths necessary.	Directions for use (frequency or schedule, if appropriate (e.g., at 0, six, eight weeks, etc.):

C. Clinical Information

Diagnosis: Is this medication for an off-label use? ☐ Yes ☐ No	Date of initial diagnosis: Month _____ Year _____	Hepatitis C genotype:	Anticipated duration for treatment:
Does patient have any relevant drug allergies? ☐ Yes ☐ No	Nature of allergy, if applicable:		Current patient weight:

1. Treatment naïve? ☐ Yes ☐ No
   If no, please fill out Section D below.
2. Has patient had detectable Hepatitis C RNA within the last six months? ☐ Yes ☐ No
3. Patient's most-recent METAVIR fibrosis score by liver biopsy: _____
4. Is patient a liver transplant recipient? ☐ Yes ☐ No
   If yes, where and when: _____
5. Does patient have Type 2 or 3 essential cryoglobulinemia present with end-organ manifestations? ☐ Yes ☐ No
   If yes, describe: _____
6. Is glomerular disease present?
   If yes, describe: _____ ☐ Yes ☐ No
7. Does patient have compensated liver disease (Child Pugh ≤ 6)? ☐ Yes ☐ No
8. Does patient have extrahepatic manifestations of Hepatitis C infection? ☐ Yes ☐ No
   If yes, describe and provide documentation: _____

Please provide all relevant clinical information to support medical necessity of drug therapy requested including any relevant lab tests which may support choice/monitoring of drug therapy:

Lab tests attached/scanned: ☐ Yes ☐ No

Please scan/attach any additional information that may be relevant in atypical cases that support the drug therapy choice.

D. Criteria for Initial Coverage

Prior/Current medication therapies

Drug Name	**Dosing Regimen**	**Start Date** (YYYY/MM)	**End Date** (YYYY/MM)	**Patient Response** (if discontinued, provide details of intolerance, contraindication, or failure at maximum dose)
		/	/	
		/	/	
		/	/	
		/	/	

E. All Other Medical Conditions and Drug Therapies Relevant to Your Health State		
Condition/Diagnosis	**Date Diagnosed** (MM/YYYY)	**Current Medications**
	/	
	/	
	/	
	/	

Please be advised further information may be requested if needed to facilitate determination of coverage.

Complete requests will be processed within five business days. However, should your patient's condition require hospitalization, please contact ASEBP Pharmacy Services at 780-431-3367 for same-day processing.

Please note that administering a compassionate (bridge) dose to a covered member without prior authorization from ASEBP does not guarantee continued coverage, which is based on our eligibility criteria.

Prescribing physician signature: _____ Date: _____