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), as the third party administrator of the ARTA Retiree Benefits Plan, is used to determine eligibility for this benefit, to provide you with information regarding additional resources available to you through your benefits (e.g., 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.

By signing below, you authorize ASEBP to access, use and disclose all prescription utilization information or other personal information in ASEBP's possession, including where applicable, your prescription drug claims history while participating under the ASEBP plan, which may be relevant to the adjudication of claims under the ARTA Benefits Plan for the purposes of administering and renewing the ARTA Enhanced Special Authorization Process. You further understand that you may revoke this consent at any time by providing written notice to ASEBP and acknowledge that doing so may affect your eligibility to receive benefits related to this application.

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 ASEBP's Privacy Policy at www.asebp.ca/privacy or contact the privacy officer at 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

ONE-YEAR COVERAGE for the treatment of multiple sclerosis (MS).

MS disease modifying therapy (DMT) requested:

❑ Aubagio (teriflunomide) ❑ Betaseron/Extavia (interferon beta-1b) ❑ Rebif (interferon beta-1a)
❑ Tecfidera (dimethyl fumarate) ❑ Avonex (interferon beta-1a) ❑ Copaxone (glatiramer acetate)

❑ Other: _____

This request is a: ❑ New request ❑ Restart request ❑ MS DMT switch

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:	Date of initial diagnosis:	Anticipated duration for treatment (max. approval is one year):
❑ Relapsing-remitting multiple sclerosis ❑ Secondary-progressive multiple sclerosis with relapses ❑ Other (please specify): _____ Is this medication for an off-label use? ❑ Yes ❑ No	Month _____ Year _____	
Does patient have any relevant drug allergies? ❑ Yes ❑ No	Nature of allergy, if applicable:	Current patient weight:

Most recent Expanded Disability Status Scale (EDSS) score: _____ Date: _____

Previous EDSS score *(if available)*: _____ Date: _____

Qualifying relapses/attacks: Please provide dates of most recent relapses/attacks *(an attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 24 hours in the absence of fever, and preceded by stability for at least one month).*

Date of Relapse (YYYY/MM/DD)	**Type of Relapse** (One MRI relapse may substitute for one clinical relapse)
	❑ Clinical relapse ❑ MRI relapse (T1 gadolinium-enhancing lesions(s)) ❑ Other: _____
	❑ Clinical relapse ❑ MRI relapse (T1 gadolinium-enhancing lesions(s)) ❑ Other: _____
	❑ Clinical relapse ❑ MRI relapse (T1 gadolinium-enhancing lesions(s)) ❑ Other: _____
	❑ Clinical relapse ❑ MRI relapse (T1 gadolinium-enhancing lesions(s)) ❑ Other: _____

If this is NOT a new request:

Has the patient been on MS DMT since the relapse(s)? ❑ No ❑ Yes

Indicate if there have been any interruptions in therapy since starting MS DMT: ❑ No ❑ Yes; indicate:

a. Reason for interruption of therapy: _____
b. Time period of interruption: From (YYYY/MM/DD): _____ To (YYYY/MM/DD): _____
c. How many relapses did the patient experience while off therapy? _____

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)

If a **switch** to a **different DMT** is requested, please provide reason:

E. All Other Medical Conditions and Drug Therapies Relevant to Your Health State

Condition/Diagnosis	Date Diagnosed (YYYY/MM)	Current Medications

F. Renewal Coverage Criteria

Requested drug, dose and interval:	Date patient started current medication:	Anticipated duration for treatment (max. approval is one year):	Current patient weight:
Drug name: _____ Dose: _____mg Interval: _____	Month _____ Year _____		

Evidence of continued benefit (improvement or stabilization) as shown by at least ONE of the following:

- ❑ Reduction in relapse/attack rate (decrease from _____ relapses/attacks per year to _____ relapses/attacks per year)
- ❑ Improvement or stability of EDSS score
  - Most recent EDSS score: _____ Date: _____
  - Previous EDSS score: _____ Date: _____
- ❑ MRI scan: reduction or stability in lesion load
- ❑ MRI scan: reduction in gadolinium enhancing lesions
- ❑ Overall clinical impression of benefit (please provide details):

Please provide any additional comments regarding patient's current medical status as applicable:

Please provide details explaining a lapse, for any period of more than 120 days, of the request medication during the previous approval period.

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 plan member without prior authorization from ARTA does not guarantee continued coverage, which is based on our eligibility criteria.

Prescribing physician signature: _____ Date: _____