MEDAVIE BLUE CROSS™

PRIOR AUTHORIZATION REQUEST

PROCEDURES FOR PRIOR AUTHORIZATION

Completed forms can be faxed in confidence to 1-514-286-8480 for residents of Quebec and 1-844-661-2640 for residents of all other provinces

Upon receipt, this request will be confidentially reviewed according to payment criteria developed by Medavie Blue Cross in consultation with independent health care consultants. In some cases, additional clinical or diagnostic information may be required to process your claim.

For Quebec residents, the criteria for prior authorization are adjusted to meet the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

- Prior Authorization is a pre-approval process to determine if certain products will be reimbursed under a member's benefit plan.
- Please complete entire form. Incomplete forms cannot be processed.
- **For certain medications, approval for reimbursement may be conditional on confirmation of enrollment in the patient support program.**
- Prior Authorization may be limited to a specified period or quantity of medication.
  Some Medavie Blue Cross plans may require you to purchase a drug requiring prior authorization from a preferred pharmacy*. If your prior authorization request is approved, a case manager may contact you, your physician, or Patient Assistance Program to provide information about the program and to arrange to have your prescription transferred to the preferred pharmacy.
  **Not applicable in Quebec*.
- In cases where a request for Prior Authorization is declined, Medavie Blue Cross is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.
- Any costs associated with the completion of this form or obtainment of additional medical information are the responsibility of the member.
- Renewal of the Prior Authorization will be considered by Medavie Blue Cross upon request from the patient/member. The renewal request should include information from the physician supporting continued use of the medication.
- Prior Authorization coverage is contingent on your continued status as a Medavie Blue Cross cardholder or beneficiary.
- If this is a request under the *Mesure du patient d'exception* for a Quebec resident, please include a completed *Patient d'exception* form that can be found here: www.medaviebc.ca/en/resources, in addition to this document.
- If you would like more information about our Patient First Network, including how your Patient Support Program can become integrated with our new enhanced Prior Authorization processes, please send an e-mail to: patientfirstnetwork@medavie.bluecross.ca.

Residents of All Other Provinces
PO BOX 220, MONCTON (NB) E1C 8L3
TEL.: 1-800-667-4511 FAX: 1-844-661-2640

Residents of Quebec
PO BOX 3300, STATION B, MONTREAL (QC) H3B 4Y5
TEL.: 1-888-588-1212 FAX: 1-514-286-8480

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PRIOR AUTHORIZATION REQUEST

1 PHARMACY INFORMATION

This section is to be completed by the Professional coordinating the request on behalf of the member (PSP, Cancer Care Navigator or Pharmacy)

Decision communication preference: ☐ Fax, Number: _____ ☐ Telephone, Number: _____

Name of Program/Pharmacy: _____

Contact Name: _____ Contact E-mail: _____

2 PATIENT INFORMATION

Part A

Patient Name: _____ Date of Birth: _____ (mm/dd/yyyy)

E-mail address of patient (or of legal guardian if patient is underage): _____

Address: _____ Suite: _____ City: _____

Province: _____ Postal Code: _____ Telephone Number: _____

Policy Number: _____ ID Number: _____

Do you have valid Medicare coverage in your current province of residence? ☐ Yes ☐ No

Have you already purchased this prescription? ☐ Yes ☐ No

Please attach your paid-in-full receipt with this request form. If you have already submitted your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt. Date: _____ (mm/dd/yyyy)

Part B – Coordination of Benefits

Do you or any dependant have coverage for this drug under any other plan or program? ☐ Yes ☐ No **If Yes, complete the following:**

Policy Number: _____ Carrier: _____

(If applicable, please attach Explanation of Benefits from prior carrier with complete form)

If the patient is a dependent, provide the birth day and month of the cardholder for the other carrier: _____ (mm/dd)

Public-Funded Program – Have you applied for coverage through a public-funded program? ☐ Yes ☐ No

If No, please indicate why: _____

Part C – Authorization

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at **www.medaviebc.ca.**

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at www.medaviebc.ca or call 1-800-667-4511.

Signature of Patient: **Date:** _____ (mm/dd/yyyy)

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3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3A Patient Support Program (PSP) Enrollment

Is patient enrolled in the Patient Support Program? ☐ No ☐ Yes, specify Program ID #: _____

Indicate the name of the Patient Support Program: _____

PSP phone #: _____ PSP Fax #: _____

Product Name	Strength	Dosage	Diagnosis

Patient weight: _____ ☐ lbs ☐ kg Number of vials per dose: _____

Expected duration of therapy: _____ Date of diagnosis: _____ (mm/dd/yyyy)

Was treatment initiated in hospital? ☐ Yes ☐ No

Where is medication being administered? _____

Indicate the specialty of the physician who initiated or recommended the treatment: _____

For Initial Request, please complete Section 3B. For Renewals, please complete Section 3C.

3B Initial Request

Please list all the drugs that were previously tried, or could not be tried because of contraindication. The information for the following drug categories (relative to each diagnosis) must be provided, including details on the contraindication if applicable.

- **Rheumatoid Arthritis: DMARDs, methotrexate**
- **Psoriatic Arthritis: DMARDs, methotrexate, sulfasalazine, NSAIDs**
- **Plaque Psoriasis: methotrexate, cyclosporine, systemic agents**
- **Crohn's Disease: aminosalicylates, corticosteroids, immunosuppressants**
- **Ulcerative Colitis: corticosteroids, aminosalicylates, immunosuppressants**
- **Non-Infectious Uveitis: corticosteroids, equivalent glucocorticoids, methotrexate**
- **Ankylosing Spondylitis: NSAIDs, DMARDs**
- **Juvenile Idiopathic Arthritis: NSAIDs, DMARDs, methotrexate**
- **Hydradenitis Suppurativa: systemic antibiotics**

Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication

Is the drug being prescribed according to the Health Canada product monograph? ☐ Yes ☐ No

*NOTE: Do not provide genetic test results

Approved indications from Health Canada:

1. **Rheumatoid Arthritis**

Moderate to severely active disease: ☐ Yes ☐ No Positive rheumatoid factor ☐ Yes ☐ No

Number of articulations with active synovitis: _____ Radiologically measured erosions: ☐ Yes ☐ No

Confirm all that are applicable (prior to treatment):

☐ An elevated sedimentation rate. Specify: _____ mm/h

☐ An elevated C-reactive protein level. Specify: _____ mg/L

☐ Score on the Health Assessment Questionnaire (HAQ): _____

☐ CDAI Score: _____

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3B Initial Request (cont'd)

2. **Ankylosing Spondylitis**

☐ Peripheral Ankylosing Spondylitis ☐ Axial Ankylosing Spondylitis

BASDAI Score (date) : _____ (_____) (mm/dd/yyyy) BASFI Score (date): _____ (_____) (mm/dd/yyyy)

☐ Score on the Health Assessment Questionnaire (HAQ): _____

Does the patient exhibit uveitis? ☐ Yes ☐ No

3. **Psoriatic Arthritis**

☐ Rheumatoid type ☐ Type other than rheumatoid

☐ Peripheral Psoriatic Arthritis ☐ Axial Psoriatic Arthritis

Number of articulations with active synovitis: _____ Radiologically measured erosions: ☐ Yes ☐ No

Confirm all that are applicable (prior to treatment):

☐ An elevated sedimentation rate. Specify: _____ mm/h

☐ An elevated C-reactive protein level. Specify: _____ mg/L

☐ Score on the Health Assessment Questionnaire (HAQ): _____

☐ BASDAI Score (date) : _____ (_____) (mm/dd/yyyy)

4. **Juvenile Idiopathic Arthritis**

Please indicate any additional information pertaining to this request:

5. **Plaque Psoriasis**

☐ Induction therapy ☐ Maintenance therapy Therapy start date: _____ (mm/dd/yyyy)

Date of initial evaluation (pre-treatment): _____ (mm/dd/yyyy) Date of most recent evaluation: _____ (mm/dd/yyyy)

PASI Score at initial evaluation : _____ Most recent PASI Score (current): _____

DLQI Score at initial evaluation: _____ Most recent DLQI Score (current): _____

Percentage of body surface area affected (pre-treatment): _____ % Percentage of body surface area affected (current): _____ %

Presence of large plaques (location): _____

Failure to phototherapy: ☐ Yes ☐ No Number of sessions: _____ Duration of treatment (in months): _____

Indicate why the phototherapy treatment had to be stopped: _____

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3B Initial Request (cont'd)

6. **Hidradenitis Suppurativa**

Hurley Stage: ☐ I ☐ II ☐ III Count of abscesses / inflammatory nodules / lesions: _____

7. **Crohn's Disease**

Moderate to severe active Crohn's disease : ☐ Yes ☐ No Fistulizing Crohn's Disease: ☐ Yes ☐ No

For Crohn disease in adults:

HBI Score: _____ CDAI Score : _____

For pediatric Crohn disease:

PCDAI Score: _____

8. **Ulcerative Colitis**

Moderate to severe ulcerative colitis : ☐ Yes ☐ No

Mayo Score: _____

Endoscopic subscore (Mayo Score): _____

Partial Mayo Score: _____

Please provide information to support starting advanced therapy without adequate trial of conventional therapy:

9. **Non-Infectious Uveitis**

Specify the diagnosis of non-infectious uveitis the patient suffers from: ☐ Intermediate ☐ Posterior ☐ Panuveitis

The disease is ☐ active ☐ inactive

The patient is corticosteroid-dependant: ☐ Yes ☐ No

The patient has a documented history of having at least one disease flare within 18 months: ☐ Yes ☐ No

If the answer is Yes, indicate if the flare occurred during or up to a maximum of 28 days after tapering off the oral corticosteroid therapy: ☐ Yes ☐ No

Indicate the number of active inflammatory chorioretinal or retinal vascular lesions: _____

According to the *Standardization of Uveitis Nomenclature* Working Group criteria and the *NEI* criteria, indicate the following values:

Anterior chamber cell grade: _____ Anterior chamber vitreous haze grade: _____

According to the *Early Treatment in Diabetic Retinopathy Study* table, specify the following:

Best-corrected visual acuity (BCVA): _____

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3C Renewal Request

Please provide information on the evolution of the disease to evaluate the response to treatment

Date of initial evaluation (pre-treatment): _____ (mm/dd/yyyy)

Date of most recent evaluation: _____ (mm/dd/yyyy)

1. **Rheumatoid Arthritis**

Number of articulations with active synovitis at initial evaluation (pre-treatment): _____

Number of articulations with active synovitis at most recent evaluation: _____

ACR Score: _____

Other items, if initially measured	Initial result	Most recent result
C-reactive protein value (mg/L):		
Sedimentation rate value (mm/h):		
Score in the Health Assessment Questionnaire (HAQ):		
CDAI score:		

Back to work, if applicable (date): ☐ Yes ☐ No (_____) (mm/dd/yyyy)

2. **Ankylosing Spondylitis**

Item initially measured	Initial result	Most recent result
BASDAI Score :		
BASFI Score:		
Score in the Health Assessment Questionnaire (HAQ):		

Back to work, if applicable (date): ☐ Yes ☐ No (_____) (mm/dd/yyyy)

3. **Psoriatic Arthritis**

Number of articulations with active synovitis at initial evaluation (pre-treatment): _____

Number of articulations with active synovitis at most recent evaluation: _____

ACR Score: _____

Other items, if initially measured	Initial result	Most recent result
C-reactive protein value (mg/L):		
Sedimentation rate value (mm/h):		
Score in the Health Assessment Questionnaire (HAQ):		
BASDAI Score :		

Back to work, if applicable (date): ☐ Yes ☐ No (_____) (mm/dd/yyyy)

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3C Renewal Request (cont'd)

4. **Juvenile Idiopathic Arthritis**

Please provide evidence of the beneficial effect of the treatment:

5 **Plaque Psoriasis**

PASI Score at initial evaluation (pre-treatment): _____ Most recent PASI Score (current): _____

DLQI Score at initial evaluation (pre-treatment): _____ Most recent DLQI Score (current): _____

Percentage of body surface area affected (pre-treatment): _____ % Percentage of body surface area affected (current): _____ %

Significant improvement of the lesions: ☐ Yes ☐ No

6. **Hidradenitis Suppurativa**

Is there improvement but suboptimal response after at least 12 weeks of treatment? ☐ Yes ☐ No

Documented decrease in the number of lesions: ☐ Yes ☐ No

Number of abscesses / inflammatory nodules / lesions at the initiation of treatment (pre-treatment) : _____ Number of abscesses / inflammatory nodules / lesions at the most recent evaluation : _____

Increase in fistulas or drainage: ☐ Yes ☐ No

7. **Crohn's Disease**

For Crohn disease in adults:

HBI Score at initial evaluation (pre-treatment) : _____ Most recent HBI Score (current) : _____

CDAI Score at initial evaluation (pre-treatment) : _____ Most recent CDAI Score (current) : _____

For pediatric Crohn disease:

PCDAI Score at initial evaluation (pre-treatment) : _____ Most recent PCDAI Score (current) : _____

8. **Ulcerative Colitis**

Medical assessment	Result at initial evaluation	Result at most recent evaluation
Mayo Score:		
Partial Mayo Score[1]:		
Rectal bleeding subscore (Mayo Score):		
Endoscopic subscore (Mayo Score):		

[1]Mayo score form which the endoscopic subscore is substracted

Has the partial Mayo score been maintained or lower? ☐ Yes ☐ No

Has there been improvement in stool frequency or rectal bleeding? ☐ Yes ☐ No

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3C Renewal Request (cont'd)

9. **Non-Infectious Uveitis**

New inflammatory chorioretinal or retinal vascular lesions to baseline: ☐ Yes ☐ No

Anterior chamber cell grade at initial evaluation (pre-treatment): _____

Anterior chamber cell grade at most recent evaluation: _____

Anterior chamber vitreous haze grade at initial evaluation (pre-treatment): _____

Anterior chamber vitreous haze grade at most recent evaluation: _____

Indicate if there was worsening of best-corrected visual acuity by 15 or more letters on the *Early Treatment Diabetic Retinopathy Study* chart, relative to the best state previously achieved: ☐ Yes ☐ No

BCVA result at initial evaluation (pre-treatment): _____ BCVA result at most recent evaluation: _____

For Pediatric Uveitis :

Has there been improvement or stability of vision? ☐ Yes ☐ No

Has there been sustained inactive disease? ☐ Yes ☐ No

Were corticosteroids tapered or discontinued? ☐ Yes ☐ No

3D Additional Information

Please indicate any additional information pertaining to this request

MEDAVIE BLUE CROSS™

PRIOR AUTHORIZATION REQUEST

HEALTH PROFESSIONAL STATEMENT

I certify that I have reviewed all pages of this request and that all information provided is true, correct and complete.

First Name: _____ Last Name: _____ Permit Number: _____

Specialty: _____

Clinic Name: _____

Address: _____ Suite: _____

City: _____ Province: _____ Postal Code: _____

E-mail: _____ Telephone: _____ Fax: _____

Signature: Date: _____
(mm/dd/yyyy)

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit.

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