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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.

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1 PHARMACY INFORMATION	
This section is to be completed by the Professional coordinating the re Pharmacy)	quest on behalf of the member (PSP, Cancer Care Navigator or
Decision communication preference:	Telephone, Number:
Name of Program/Pharmacy:	
Contact Name:	Contact E-mail:
2 PATIENT INFORMATION	
Part A	
Patient Name:	Date of Birth:
E-mail address of patient (or of legal guardian if patient is underage):	(mm/dd/yyyy)
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 alre your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to the oldest receipt	
Part B – Coordination of Benefits	
Do you or any dependant have coverage for this drug under any other plan	or program?
Policy Number:	Carrier:
(If applicable, please attach Explanation of Benefits from prior carrier with complete for	m)
If the patient is a dependent, provide the birth day and month of the cardhold	ler for the other carrier:(mm/dd)
Public-Funded Program – Have you applied for coverage through a public-fu	
If No, please indicate why:	
Part C – Authorization	
	d and used by Medavie Blue Cross to administer the terms of my policy or the ducts and services that I am eligible for as a member of a policy, and other nent at www.medaviebc.ca.
released to following third parties as required for the purposes of administe	ch as claim, health and/or financial related data may be collected from and/or tring and managing the benefits outlined in the policy of which I am an eligible surance companies, regulatory authorities and investigative bodies, services nt.
Where allowed by law, my information may be shared with Medavie Blue collected. If I am a resident of Quebec, this includes transferring or disciproviders outside of that province.	Cross employees or service providers in jurisdictions other than where it was osing my personal information to Medavie Blue Cross employees or service
I understand that my consent is only valid for the time it is needed to achieve my consent at any time. However, in some instances doing so may preven may be useful to me and/or my dependents. This consent complies with federal consent	the purposes outlined herein, unless I withdraw it. I understand I may withdraw t Medavie Blue Cross from providing me with certain products or services that eral and provincial privacy laws.
For more details about our information practices, including how your persor you have concerns or questions, please see our Medavie Blue Cross Privacy	nal information is protected, how to access or correct personal information, or if y Statement available at www.medaviebc.ca or call 1-800-667-4511.
Signature of Patient:	Date:

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



3	SPECIALTY DRUG INFORMAT	ION				
	ne of patient:					_
	cy Number:					
E-m	ail address of patient or of legal o	guardian if patient	ıs underage:			
3A F	Patient Support Program (PSP)	Enrollment				
-	tient enrolled in the Patient Suppo	-		-		
	ate the name of the Patient Suppo					
P3P	phone #:			PSP Fax #:		
	Product Name	Strength	Dosage		Diagnosis	
Exp	pected duration of therapy:	week	s V	Vas treatment initiated in l	hospital?	□ No
	ere is medication being administe				•	
Indio	cate the specialty of the physiciar	n who initiated or re	ecommended the	treatment:		
	nitial Request, please complete	Section 3B.				
3B	Initial Request					
Is the	e drug being prescribed acc	ording to the H	ealth Canada p	roduct monograph?	☐ Yes ☐ No	
		*** Please	e provide the b	ood tests results ***		
1.	Indicate the genotype: 1	1a	□3 □4 □5	□6		
	*NOTE: Do not provide genetic test	results				
2.	HCV viral load value from within		•	• •	• •	
	→ as determined by: ☐ A		」COBAS TaqMa	n v.2.0 by Roche ∐ Othe	r. Specify:	
3.	Fibrosis stage: F0 F1 (Must enclose copy of staging report					
4.	Is the patient cirrhotic: Yes	\square No \rightarrow If yes, i	ndicate if cirrhosis	s is Compensated] Decompensated	
	Baseline NS5A: Yes N	0				
5.	Please list all the drugs that wer	e previously tried	and response to t	reatment :		
	Previous treatme	ent	Response	to treatment or contrai	ndications	Duration of treatment
	☐ Patient is treatment naïve for	r HCV		N/A		N/A
•	□RBV		☐ Therapeutic	failure		
	□INF		☐ Partial respo	nse		
	Sofosbuvir		☐ Null respons	е		
	☐ RBV / INF combination		Relapse			
	RBV / Sofosbuvir combination	on	☐ Viral escape			From: ———
	☐ Protease inhibitor		☐ Intolerance (specify): ————		(mm/dd/yyyy)
	BOC			tion (specify):		To: ———
	□TVR		Other (speci	fy):		(mm/dd/yyyy)
	SIM					
	□ NS 3/4a					
	☐ NS5A protein inhibitor					
	Other (specify):					

3	SPECIALTY DRUG INFORMATION		
	me of patient:		
	icy Number:		
E-n	nail address of patient or of legal guardian if pa	tient is underage:	
3B	Initial Request (cont'd)		
6.	Prognostic factors (check if applicable): HIV or HBV co-infection (specify):		
	☐ Chronic kidney disease stage 3, 4 or 5 as	defined by K/DOQI	
	☐ Organ transplantation (pre or post-graft)		
	☐ Use of antidiabetic drugs		
	☐ Woman of childbearing age who is planni	ng to get pregnant within the next year	
	☐ Other liver disease with evidence of hepa	tic steatosis	
	☐ Severe extra-hepatic manifestations (spe	cify):	
	Other (specify):		
7.	Administration of treatment		
	☐ In monotherapy	☐ In association with RBV	☐ In association with INF
	☐ In association with Daclatasvir	☐ In association with Sofosbuvir	☐ In association with RBV + INF
	☐ In association with another drug. Specify:		
8.	For GALEXOS only—Indicate if there is pres *NOTE: Do not provide genetic test results	sence of Q80K mutation*:	
9.	Please indicate any additional informati	on pertaining to this request:	





First Name:	Last Name:	Permit Number:
Specialty:		
Clinic Name:		
Address:		Suite:
City:	Province:	Postal Code:
E-mail:	Telephone:	Fax:
Signature:		Date:
		(mm/dd/yyyy)

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No.