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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 Medavie Blue Cross, please indicate the date of the oldest receipt the o				
Part B – Coordination of Benefits	· · · · · · · · · · · · · · · · · · ·			
Do you or any dependant have coverage for this drug under any other plan of	or program? Yes No If Yes, complete the following:			
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	er for the other carrier:(mm/dd)			
Public-Funded Program – Have you applied for coverage through a public-funded program?				
If No, please indicate why:				
Part C – Authorization				
	d and used by Medavie Blue Cross to administer the terms of my policy or the lucts 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 ring 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 discl providers 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 consents are complied to the consent complied with federal consents.	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 ral and provincial privacy laws.			
For more details about our information practices, including how your person you have concerns or questions, please see our Medavie Blue Cross Privacy	al information is protected, how to access or correct personal information, or if 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	INFORM	ATION			
Name of patient:					Date of Birth:
_				ID Number:	
E-mail address of patier	nt or or leg	ai guardian ii palien	it is underage:		
3A Patient Support Pro	ogram (PS	P) Enrollment			
· ·					
				PSP Fay #	
T OF phone #.	PSP phone #: PSP Fax #:				
Product Name		Strength	Dosage		Diagnosis
Patient weight:		□ lbs □ ka	Numb	per of vials / syringes per do	ose:
Date treatment was initi					reatment:
Date of diagnosis:		(mm/dd/yyyy)		Was treatment initiated	d in hospital? ☐ Yes ☐ No
Where is medication be					· – –
	-			the treatment:	
Indicate if the disease o	r injury is v	vork related: 🔲 Ye	es 🗌 No		
For Initial Request, plea	se compl	ete sections 3B an	ıd 3D. For Ren	iewals, please complete s	sections 3C and 3D.
3B Initial Request					
following drug categoric	es (relativ o insufficie ciency in p	e to each diagnos nt secretion of endo	is) must be progenous growth	ovided, including details hormone in children and ac	aindications. The information for the on the contraindication if applicable.
- Idiopathic short statu		ppin			
Category	Prod	uct Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication
*NOTE: Do not provide gene			n Canada pro	duct monograph? 🔲 Ye	es 🔲 No
Approved indications from Health Canada:					
1. Delayed growth due to insufficient secretion of endogenous growth hormone in children and adolescents					
Indicate whether the patient suffers from any of these conditions:					
☐ Achondroplasia					
☐ Delayed growth o	of a genetic	or familial type			
☐ Other. Specify:					

3	3 SPECIALTY DRUG INFORMATION				
	Policy Number: ID Number:				
E-I	E-mail address of patient or of legal guardian if patient is underage:				
ВВ	Initial Request (cont	'd)			
1.	Delayed growth due	e to insufficient secretion of endogenous growth hormone	n children and adolescents (cont'd)		
	Medical assessment:				
	Growth:	ed Unterminated			
	Growth rate for their be from hypoglycemia secon	one age below the 25th percentile calculated over a minimum p	eriod of twelve months (except in children suffering		
	☐ Yes ☐ Othe	er. Specify:			
	Patient's bone age:	years			
	Does the patient have	a documented decreased serum concentrations of growth horn	nones? Yes No		
	Somatotropin serum o				
	→ Somatotropin level	s measured in the first test (date): μg/L	()		
	→ Somatotropin level	s measured in the second test (date): µg/L	()		
2.	Growth hormone de	eficiency in patients whose bone growth has terminated			
	Specify the cause of the	ne growth hormone deficiency:			
	☐ Adult-onset deficie	ncy: Childho	ood-onset deficiency:		
	→ □ Secondar	y to a hypophyseal or hypothalamic disease	As a result of congenital causes		
	☐ Secondar	y to radiation therapy	As a result of genetic causes		
	☐ Secondar	y to trauma	As a result of acquired causes		
	☐ Secondar	y to surgery	As a result of idiopathic causes		
	☐ Other. Specify:				
	Does the patient have	a documented decreased serum concentrations of growth horn	nones?		
_	Type and measureme	nt of growth hormone deficiency:			
	Type of deficiency	Measurement of serum or plasma somatotropin	Pharmacological stimulation test performed		
		Somatotropin levels measured in the first test:			
		μg/L Date :(mm/dd/yyyy)	☐ Insulin hypoglycemia test		
	<i>Isolated</i> growth hormone deficiency	Somatotropin levels measured in the second test:			
	,	·	☐ Glucagon test		
		μg/L Date :(mm/dd/yyyy)			
	Multiple	Somatotropin levels:	☐ Insulin hypoglycemia test		
	hypophyseal hormone deficiency	μg/L Date :	☐ Glucagon test		
L					

3	SPECIALTY DRUG INFORM	ATION			
	me of patient:				
	licy Number:				
<u> </u>	mail address of patient or of leg	ai guardian if pa	atient is underage	i	
3B	Initial Request (cont'd)				
3.	Turner's syndrome				
	☐ Diagnosis based on karyoty	ype analysis (co	omplete absence c	or structural anoma	ly of one of the X chromosomes)
	☐ Diagnosis based on high-th	roughput pyros	sequencing		
	Other. Specify:				
	Patient's bone age:	years			
4	Deleve demonstrate in abildre	. h	4h a io ao a 4a4i a o	1	
4.	Delayed growth in children		•	•	
	Standard deviation of weight a				
	Standard deviation of height at				
	Growth rate over the last year	(standard devia	ation score):		<u> </u>
5.	Delayed growth related to	chronic renal i	nsufficiency unti	l they undergo a l	kidney transplant, in children and adolescents
	The renal transplant is:				
	☐ Done or planned (date): ()	☐ Not planne	d
	Medical assessment:	(mm/aa/yyyy	/)		
	Growth: Terminated	Unterminated			
				2	
	Glomerular filtration rate:			/1.73m² or ∐ ı	mL/min/1.73m²
	Z score (HSDS) or Δ Z score r	esults:			
	Z score (HSDS):	□ -3 SD —	□ -2 SD —	□ -1 SD 	_
		□ 0 SD	☐ 1 SD	☐ 2 SD	☐ 3 SD
	or	☐ -3 SD	☐ -2 SD	☐ -1 SD	
	 Δ Z score (HSDS)*: (*if height is below the 10th percentile) 	□ -3 3D □ 0 SD	☐ -2 SD	□ -1 3D	☐ 3 SD
				□ 200	
6.	Idiopathic short stature				
	The patient has the following of	haracteristics (check all that appl	<u>y):</u>	
	☐ Current height is below -2.2	?5 standard dev	viations (SD) of the	mean for age	
	☐ Predicted adult height is un	likely to fall with	hin the normal ran	ge (63 inches [160	cm] for males and 59 inches [150 cm] for females)
	☐ Epiphyses are not closed				
	☐ Other causes associated w	ith short stature	e have been exclu	ded	
	☐ None of the above				

3	SPECIALTY DRUG INFORMATION	
	ame of patient: Date of Birth:	_
	olicy Number: mail address of patient or of legal guardian if patient is underage:	
3B	Initial Request (cont'd)	
UD.		
7.	Prader-Willi syndrome	
	Are the patient's epiphyses closed? ☐ Yes ☐ No	
	The patient has the following characteristics (check all that apply):	
	☐ Current height is below -2.25 standard deviations (SD) of the mean for age	
	☐ Predicted adult height is unlikely to fall within the normal range (63 inches [160 cm] for males and 59 inches [150 cm] for females)	
	□ None of the above	
3C	Renewal Request	
Ple	ase provide information on the evolution of the disease to evaluate the response to treatment.	
Da	ate of initial evaluation (pretreatment): Date of most recent evaluation: (mm/dd/yyyy)	
	(IIIII/dd/yyyy)	
1.	Delayed growth due to insufficient secretion of endogenous growth hormone in children and adolescents	
	Patient's bone age: years	
	Growth rate ≥ 2 cm per year (evaluated on two consecutive visits at a 3-month interval): ☐ Yes ☐ No. Specify:	
	Is there an increase in serum IGF-1 concentrations or has the patient achieved sustained target serum concentrations?	0
	Is there a documented change in the patient's stature? \Boxed Yes \Boxed No	
2.	Growth hormone deficiency in patients whose bone growth has terminated	
	Is there an increase in serum IGF-1 concentrations or has the patient achieved sustained target serum concentrations?	0
	Is there a documented change in the patient's stature? ☐ Yes ☐ No	
3.	Turner's syndrome	
	Patient's bone age: years	
	Growth rate ≥ 2 cm per year (evaluated on two consecutive visits at a 3-month interval):	
	☐ Yes ☐ No. Specify:	
	Is there an increase in serum IGF-1 concentrations or has the patient achieved sustained target serum concentrations?	0
	Is there a documented change in the patient's stature? ☐ Yes ☐ No	

3	SPECIALTY DRUG INFORMATION
	ame of patient: Date of Birth:
	olicy Number: ID Number:
	mail address of patient or of legal guardian if patient is underage:
3C	Renewal Request (cont'd)
4.	Delayed growth in children born small for their gestational age
	Beneficial effects obtained:
5.	Delayed growth related to chronic renal insufficiency until they undergo a kidney transplant, in children and adolescents
	Increase of Δ in Z score (HSDS) during the <u>first twelve months</u> of treatment:
	☐ Yes ☐ No. Specify:
	Growth rate ≥ 2 cm per year (evaluated on two consecutive visits at a 3-month interval):
	☐ Yes ☐ No. Specify:
	Ossification of the conjugative cartilages observed:
	☐ Yes ☐ No
	Final expected height reached:
	☐ Yes ☐ No
	Is there an increase in serum IGF-1 concentrations or has the patient achieved sustained target serum concentrations?
	Is there a documented change in the patient's stature? ☐ Yes ☐ No
6.	Idiopathic short stature
	If this is for the first renewal request, please complete section 6a. If this a second or subsequent renewal, please complete section 6b.
6a	a First renewal request
Ü.	
	Are the patient's epiphyses closed? \[Yes \] No
	Has height velocity increased by at least 2.5 cm/year above the baseline height velocity? ☐ Yes ☐ No
6k	Second or subsequent renewal
	Are the patient's epiphyses closed? ☐ Yes ☐ No
	Is height velocity more than 2.0 cm/year? ☐ Yes ☐ No

3	SPECIALTY DRUG INFORMATION				
Na	ame of patient: Date of Birth:				
	Policy Number: ID Number:				
E-	E-mail address of patient or of legal guardian if patient is underage:				
3C	C Renewal Request (cont'd)				
7.	Prader-Willi syndrome				
	If this is for the first renewal request, please complete section 7a. If this a second or subsequent renewal, please complete section 7b.				
7a	First renewal request				
	Are the patient's epiphyses closed? ☐ Yes ☐ No				
	Has height velocity increased by at least 2.5 cm/year above the baseline height velocity? ☐ Yes ☐ No				
7b	Second or subsequent renewal				
	Are the patient's epiphyses closed? ☐ Yes ☐ No				
	Is height velocity more than 2.0 cm/year? ☐ Yes ☐ No				
3D	Additional Information				
Please indicate any additional information pertaining to this request.					





i 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 reform may be subject to audit.	equested information in detail to help avoid	(mm/dd/yyyy) d delay in assessing claims for the above drug. This	

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

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