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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 INFORM	ATION			
Name of patient:				Date of Birth:
Policy Number:				
E-mail address of patient or of leg	al guardian if patient	is underage: _		
3A Patient Support Program (PS	SP) Enrollment			
•	· · · · · ·			
Indicate the name of the Patient Su PSP phone #:	··			
Product Name	Strength	Dosage		Diagnosis
JAKAVI (RUXOLITINIB)				
Patient weight:	☐ lbs ☐ kg	Numbe	er of vials / syringes per do	ose:
Date treatment was initiated:	(mm/dd/yyyy)		Expected duration of tr	eatment:
Date of diagnosis:			Was treatment initiated	l in hospital? ☐ Yes ☐ No
(mm Where is medication being admin	/dd/yyyy)			
Indicate the specialty of the physic				
Indicate if the disease or injury is	work related: 🗌 Ye	s 🗌 No		
For Initial Request, please compl	ete sections 3B and	d 3D. For Ren	ewals, please complete s	sections 3C and 3D.
3B Initial Request				
	re to each diagnosis nyelofibrosis: Janus k a : corticosteroids	s) must be pro	ovided, including details	indications. The information for the on the contraindication if applicable.
_	uct Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication
outogory 1 roa	docridino	Desags	Daragen of Treatment	respense to requirement of contraintagation
Is the drug being prescribed acce *NOTE: Do not provide genetic test res	_	ı Canada prod	luct monograph? 🔲 Ye	es 🗌 No
Approved indications from Health C	anada:			
1. Splenomegaly				
Splenomegaly associated with	: Primary myel	ofibrosis		
			polycythemia vera	
	-		essential thrombocythemia	ā
Splenomegaly is symptomatic	·			
→ IPSS score:	_ → Myelopr	oliferative Neo	plasm Symptom Assessm	ent Form total symptom score:
→ DIPSS score:	•		• •	• •
י סט אטופ			(mm/dd/yyyy)

3	SPE	CIALTY DRUG INFORMATION	
			Date of Birth:
	-	mber:	
	-IIIaii au	uress or patient or or legal guardian if p	atient is underage:
3B	Initia	I Request (cont'd)	
1.	Sple	enomegaly (cont'd)	
	-		Date of basic imaging:
			▶ Date of basic imaging:
	-	Palpable spleen at 5 cm or more under	the left costal margin:
2.	Poly	cythemia vera	
	\ F.C	200 again (data):	
	→ EC	OG score (date): ((mm/dd/yyyy)
	Is the	patient resistant or intolerant to hydroxy	urea therapy?
	D	uration of hydroxyurea therapy:	Dosage:
	From:	(mm/dd/yyyy)	☐ Dose of at least 2 g / day
	_	(mm/dd/yyyy)	Highest effective dose that does not result in grade 3 or more hematologic, dermatologic or digestive toxicity
	To:	(mm/dd/yyyy)	Other. Specify:
	Dogies	tange to budrowurse thereny defined by	
		tance to hydroxyurea therapy defined by	over a three-month period to maintain hematocrit below 45%
			ated with splenomegaly or failure to achieve 50% reduction in splenomegaly
			by a white blood cell count exceeding 10 x 10^9 /L and a platelet count exceeding 400 x 10^9 /L
		, ,	
		rance to hydroxyurea therapy due to:	
			cocutaneous ulcer, gastrointestinal symptoms, pneumonitis, persistent fever
			atelet count <100 × 10 ⁹ /L at the lowest dose of hydroxyurea to achieve hematologic
		response	
		Other. Specify:	
3.	<u>Acu</u>	te graft versus host disease (aGvHD)	
	Grade	:	
			HD International Consortium [MAGIC] criteria (Harris 2016): ☐ Yes ☐ No
	Did th	e GvHD occur following an allogeneic h	ematopoietic stem cell transplant?
	Is acu	te GvHD corticosteroid-refractory or cor	ticosteroid-dependent? ☐ Yes ☐ No
	⊢ ,	According to the European Society for E	slood and Marrow Transplantation (EBMT) – National Institutes of Health (NIH) – Center splant Research (CIBMTR) Task force position statement criteria (Schoemans

Name of natient:		
Policy Number:		
E-mail address of patient or of legal guardian if	patient is underage:	
B Initial Request (cont'd)		
4. <u>Chronic</u> graft versus host disease (cGv	vHD)	
Stage: ☐ Mild ☐ Moderate ☐ Sever	re	
→ According to the National Institute of H	Health (NIH) consensus criteria: ☐ Yes ☐] No
Did the GvHD occur following an allogeneic	hematopoietic stem cell transplant?	es 🗆 No
Is chronic GvHD corticosteroid-refractory or	corticosteroid-dependent?	
→ According to the NIH consensus criter	ria: ☐ Yes ☐ No	
Was the patient treated with Jakavi for acute	e graft versus host disease? ☐ Yes ☐ N	0
	<u>nt</u> :	
☐ Complete ☐ Partial ☐ Stabiliza	ation of the disease ☐ Other. Specify:	
Date of initial evaluation (pretreatment):	(mm/dd/yyyy) Date of most r	recent evaluation:(mm/dd/yyyy)
. ,		
. Splenomegaly Is this a renewal request for myelofibrosis?	☐ Yes ☐ No	
	☐ Yes ☐ No Result at initial evaluation	Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom		Result at most recent evaluation
Is this a renewal request for myelofibrosis?		Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom Assessment Form total symptom score:		Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom		Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom Assessment Form total symptom score:	Result at initial evaluation	Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom Assessment Form total symptom score: Spleen volume: Significant reduction of the splenomegaly:	Result at initial evaluation	Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom Assessment Form total symptom score: Spleen volume: Significant reduction of the splenomegaly: ☐ Confirmed by: ☐ Basic imaging	Result at initial evaluation Yes No (date):	Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom Assessment Form total symptom score: Spleen volume: Significant reduction of the splenomegaly: ☐ Confirmed by: ☐ Basic imaging	Result at initial evaluation	Result at most recent evaluation
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom Assessment Form total symptom score: Spleen volume: Significant reduction of the splenomegaly: → Confirmed by: □ Basic imaging	Result at initial evaluation Yes No (date): ination (date):	
Is this a renewal request for myelofibrosis? Myeloproliferative Neoplasm Symptom Assessment Form total symptom score: Spleen volume: Significant reduction of the splenomegaly: ☐ Confirmed by: ☐ Basic imaging ☐ ☐ Physical exami	Result at initial evaluation Yes No (date): ination (date):	

3 SPECIALTY DRUG INFORMATION				
Na	Name of patient: Date of Birth:			
	Policy Number: ID Number:			
E-I	E-mail address of patient or of legal guardian if patient is underage:			
3C	Renewal Request (cont'd)			
2.	Polycythemia vera			
	If this is for the first renewal request, please con	nplete section 2a. If this a second or subsequent renewal, please complete section 2b.		
2a	First renewal request			
	Indicate whether a beneficial clinical effect	has been observed: ☐ Yes ☐ No		
	→ If yes, specify: ☐ Reduced use of	phlebotomy to maintain hematocrit below 45%		
		otomy to maintain hematocrit below 45%		
	·	thrombocytosis and leukocytosis		
	·	symptoms associated with splenomegaly		
	☐ Non-palpable sp			
	☐ Other. Specify:			
	Platelet count: x10 ⁹ /L			
	White blood cell count:	_ x10°/L		
2b	Second or subsequent renewal			
	Indicate whether the beneficial clinical effect	et has been maintained: ☐ Yes ☐ No		
	→ If yes, specify the aspect in which the	☐ The frequency of phlebotomy procedures		
	maintenance of the beneficial clinical	☐ Hematocrit <45% without phlebotomy		
	effect was observed:	☐ Platelet count: x10 ⁹ /L		
		☐ White blood cell count: x10 ⁹ /L		
		☐ Symptoms associated with splenomegaly		
		□ Non-palpable spleen		
		☐ Other. Specify:		
		— · / —		
3.	Acute graft versus host disease (aGvH	D)		
	Response to treatment:			
	☐ Complete response			
	☐ Very good partial response			
	☐ Partial response			
	☐ Stabilization of the disease			
	☐ Other. Specify:			
	- 			

3	3 SPECIALTY DRUG INFORMATION	
Na	Name of patient: Date of Birth:	
Po	Policy Number: ID Number:	
E-	E-mail address of patient or of legal guardian if patient is underage:	
3C	C Renewal Request (cont'd)	
4.	4. <u>Chronic</u> graft versus host disease (cGvHD)	
	Response to treatment:	
	☐ Complete ☐ Partial ☐ Stabilization of the disease ☐ Other. Specify:	
	Response evaluated according to NIH consensus criteria: Yes No	
3D	D Additional Information	
	Please indicate any additional information 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)

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

No.