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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: | | | | |
| Policy Number: | | | | |
| E-mail address of patient or of leg | al guardian if patien | t is underage: | | |
| 3A Patient Support Program (PS | | | | |
| • | · · · · · · | · | - | |
| Indicate the name of the Patient Su PSP phone #: | | | | |
| T of phone #. | 1 | _ | 1 Of 1 dx #. | |
| Product Name | Strength | Dosage | | Diagnosis |
| | | | | |
| Patient weight: | ☐ lbs ☐ kg | Date of d | liagnosis: | |
| Expected duration of treatment: _ | | | | ^{mm/dd/yyyy)} is work related: |
| Was treatment initiated in hospital | | | | d? |
| · | | | | |
| Is the patient currently on, or prev | | | | nent start date: |
| | s covering this drug. | | | (mm/dd/yyyy) |
| (if not Medavie Blue Cross, ple | | | chase of this drug) | |
| For Initial Request, please compl | ete sections 3B an | d 3D. For Renewal | s, please complete s | sections 3C and 3D. |
| 3B Initial Request | | | ·· · | |
| | | | | indications. The information for the on the contraindication if applicable. |
| glucocorticoids, Tezspire | haled corticosteroids | s, long-acting β adre | - | otriene receptor antagonists, systemic ort, Nasonex, Omnaris, Rhinocort), systemic |
| Product Name | Dosage | Start Date (mm/dd/yyyy) | End Date (mm/dd/yyyy) | Response to Treatment or Contraindication |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| Is the drug being prescribed acc *NOTE: Do not provide genetic test res | | h Canada product | monograph? 🗌 Ye | s 🗌 No |
| Approved indications from Health C | Canada: | | | |
| 1. Moderate to severe chronic | c idiopathic urticar | ia | | |
| UAS7 score prior to treatment | initiation (date): | (| (mm/dd/yyyy) | .) |
| Allergy testing: ☐ Positive [| ☐ Negative | | . , , , , , , , , , , , , , , , , , , , | |
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| 3 | SPECIALTY DRUG INFORMATION |
|-----|---|
| Na | me of patient: Date of Birth: |
| | icy Number: ID Number: |
| E-n | nail address of patient or of legal guardian if patient is underage: |
| 3B | Initial Request (cont'd) |
| 1. | Moderate to severe chronic idiopathic urticaria (cont'd) |
| | Are the symptoms inducible? ☐ Yes ☐ No |
| | Is the patient experiencing recurrent urticaria, angioedema, or both? Yes No |
| | If yes, please indicate how many weeks these symptoms have been present: weeks |
| 2. | Moderate to severe persistent asthma or allergic asthma |
| | Diagnosis established using: ☐ Skin tests ☐ Blood tests ☐ Medical history ☐ Other: |
| | Test used to confirm diagnosis: Spirometry |
| | ☐ Bronchoprovocation testing (methacholine or mannitol inhalation challenge) |
| | Other. Specify: |
| | → FEV₁ increase following salbutamol reversibility test: % |
| | → Total serum IgE level: IU/mL |
| | Number of asthma exacerbations in the past 12 months: |
| | |
| | ☐ Systemic glucocorticoids for at least 3 days |
| | ☐ An emergency department visit |
| | ☐ A hospitalization |
| | ☐ None of the above |
| | Additional information: |
| | ☐ Smoker ☐ Non-smoker, indicate for how many months: |
| | Environmental issues considered and addressed as reasonably as possible: Yes No |
| | |
| 3. | Severe chronic rhinosinusitis |
| | Presence of bilateral nasal polyps: |
| | Endoscopic nasal polyp score (NPS): Left nostril: Right nostril: |
| | Has the patient had chronic rhinosinusitis symptoms for 12 weeks or more, despite intranasal corticosteroid therapy? ☐ Yes ☐ No |
| | Has the patient had sinonasal surgery? ☐ Yes ☐ No |
| | |
| | Specify the contraindication (if applicable): |
| | |

| 3 | 3 SPECIALTY DRUG INFORMATION | |
|-----|--|--|
| Na | Name of patient: Date of Birth: | |
| | Policy Number: ID Number: | |
| | E-mail address of patient or of legal guardian if patient is underage: | |
| 3B | B Initial Request (cont'd) | |
| 3. | 3. Severe chronic rhinosinusitis (cont'd) | |
| | Presence of the following elements (check all that apply): | |
| | ☐ Evidence of type 2 inflammation | |
| | → Blood eosinophil count: → Total IgE: | |
| | → Tissue eosinophil count: per high-power field | |
| | Asthma requiring regular use of inhaled corticosteroids. ACQ score: | |
| | ☐ SNOT-22 score: ☐ Significant loss of smell | |
| | ☐ SIVOT-22 Score. | |
| | | |
| 3C | C Renewal Request | |
| | | |
| Pie | lease provide information on the evolution of the disease to evaluate the response to treatment. | |
| D | Date of initial evaluation (pretreatment): | |
| | Date of initial evaluation (pretreatment): Date of most recent evaluation: (mm/dd/yyyy) | |
| | | |
| 1. | Moderate to severe chronic idiopathic urticaria | |
| | UAS7 score at initial assessment (pretreatment): UAS7 score at most recent assessment (current): | |
| | · / | |
| | History of UAS7 scores over the past 24 weeks of treatment | |
| | Date of assessment (mm/dd/yyyy) UAS7 score | |
| | (IIIII) da yyyy) | |
| | | |
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| | | |
| | | |
| | Response to treatment: | |
| | ☐ Complete response (symptoms controlled). Duration: weeks | |
| | ☐ Partial response | |
| | ☐ Relapse | |
| | | |
| | Attempt to discontinue treatment: | |
| | | |
| | | |

| 3 | SPECIALTY DRUG INFORMATION | | |
|----|--|--|----------------------------------|
| | | | Date of Birth: |
| | | ID Number: | |
| E- | mail address of patient or of legal guardian if | patient is underage: | |
| 3C | Renewal Request (cont'd) | | |
| 2. | Moderate to severe persistent asthma | or allergic asthma | |
| | Decrease in the number of courses of oral stop baseline or previous approval: | steroids required to control asthma symptoms | s compared |
| | Decrease in the dosage of <u>continual</u> oral ste symptoms compared to baseline or previous | eroids (if applicable) currently in use to contro s approval: | ol asthma ☐ Yes ☐ No |
| | Decrease in the number of hospitalizations previous approval: | and/or emergency room visits compared to b | aseline or ☐ Yes ☐ No |
| 3. | Severe chronic rhinosinusitis | | |
| | | Result at initial evaluation | Result at most recent evaluation |
| | Endoscopic nasal polyp score (NPS): | Left nostril: | Left nostril: |
| Ī | | Right nostril: | Right nostril: |
| | SNOT-22 score: | | |
| | Asthma symptoms (ACQ score): | | |
| | | rovement been maintained for the sense of s | |
| 3D | Additional Information | | |
| Г | Please indicate any additional information | pertaining to this request. | |
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| 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
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TEL.: 1-800-667-4511 FAX: 1-844-661-2640

No.