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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 to the oldest receipt to the oldest receipt the date of the oldest receipt to the oldest	
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 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 DRU	JG INFORMATION	ON			
Name of patient: Policy Number:				ID Number:	
3A Patient Support P Is patient enrolled in the Indicate the name of the	Patient Support	Program?			
PSP phone #:					
Product Nam	ne	Strength	Dosage		Diagnosis
ORENCIA (ABATACEP	т)				
Patient weight:		•		•	se:
Was treatment initiate				Date of diagnosis. —	(mm/dd/yyyy)
	•				
Indicate the specialty Indicate if the disease				I the treatment:	
For Initial Request, pl 3B Initial Request	ease complete	sections 3B a	nd 3D. For Ren	ewals, please complete s	sections 3C and 3D.
drug categories (relat - Juvenile Idiopathic - Rheumatoid Arthri - Psoriatic Arthritis:	: Arthritis: DMAR tis: DMARDs, me	Ds, methotrexat		cluding details on the co	ntraindication if applicable.
Category	Product	Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication
*NOTE: Do not provide	genetic test res	ults	Health Canad	la product monograph	n? 🗌 Yes 🗌 No
Approved indications	from Health Ca	nada:			
Juvenile Idiopat Confirm whether the		☐ the polyar	ticular type, or	☐ the systemic type	
Number of articula	itions with active	synovitis:		Following prior treatment	ts, the disease is:
Confirm all that are ☐ An elevated C-				/L ☐ An elevated se	edimentation rate. Specify: mm/h

Policy Number:	Na	me of patient:		Date of Birth :
2. Rheumatoid Arthritis Moderate to severely active disease: Yes No Positive rheumatoid factor Yes No		•		
Moderate to severely active disease:	В	Initial Request (cont'd)		
Number of articulations with active synovitis:	2.	Rheumatoid Arthritis		
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. Psoriatic Arthritis Peripheral Psoriatic Arthritis		Moderate to severely active disease: ☐ Yes ☐ I	No Positive rheumatoid fac	tor 🗌 Yes 🔲 No
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. Psoriatic Arthritis		Number of articulations with active synovitis:	Radiologically measure	d erosions:
□ An elevated C-reactive protein level. Specify: mg/L. □ Score on the Health Assessment Questionnaire (HAQ): □ CDAI Score:		Confirm all that are applicable (prior to treatment):		
Score on the Health Assessment Questionnaire (HAQ): CDAI Score: CDAI Score: CDAI Score: Axial Psoriatic Arthritis		☐ An elevated sedimentation rate. Specify:	mm/h	
□ CDAI Score:		$\hfill \square$ An elevated C-reactive protein level. Specify: $\hfill \square$	mg/L	
3. Psoriatic Arthritis		☐ Score on the Health Assessment Questionnaire	e (HAQ):	
Peripheral Psoriatic Arthritis		☐ CDAI Score:		
Number of articulations with active synovitis: Confirm all that are applicable (prior to treatment): Score on the Health Assessment Questionnaire (HAQ): BASDAI Score (date): (3.	Psoriatic Arthritis		
Confirm all that are applicable (prior to treatment): Score on the Health Assessment Questionnaire (HAQ): (mm/dd/yyyy) C 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. Juvenile Idiopathic Arthritis Number of articulations with active synovitis at initial evaluation (pre-treatment): Other items, if initially measured C-reactive protein value (mg/L): Sedimentation rate value (mm/h): Score in the Childhood Health Assessment Questionnaire (CHAQ): Number of affected joints with limitation of		☐ Peripheral Psoriatic Arthritis	☐ Axial Psoriatic Arthritis	
Score on the Health Assessment Questionnaire (HAQ): BASDAI Score (date): (Number of articulations with active synovitis:		
Score on the Health Assessment Questionnaire (HAQ): BASDAI Score (date): (Confirm all that are applicable (prior to treatment):		
C Renewal Request lease provide information on the evolution of the disease to evaluate the response to treatment Date of initial evaluation (pre-treatment): Date of most recent evaluation: (mm/dd/yyyy) 1. Juvenile Idiopathic Arthritis Number of articulations with active synovitis at initial evaluation (pre-treatment): Synovitis at most recent evaluation: Other items, if initially measured Initial Result Most recent result C-reactive protein value (mg/L): Sedimentation rate value (mm/h): Score in the Childhood Health Assessment Questionnaire (CHAQ): Number of affected joints with limitation of			e (HAQ):	
C Renewal Request Please provide information on the evolution of the disease to evaluate the response to treatment Date of initial evaluation (pre-treatment): Date of most recent evaluation:			•	
Please provide information on the evolution of the disease to evaluate the response to treatment Date of initial evaluation (pre-treatment):		(mm/dd/	уууу)	
Please provide information on the evolution of the disease to evaluate the response to treatment Date of initial evaluation (pre-treatment):		Renewal Reguest		
1. Juvenile Idiopathic Arthritis Number of articulations with active synovitis at initial evaluation (pre-treatment):		•	isease to evaluate the response to tre	atment
1. Juvenile Idiopathic Arthritis Number of articulations with active synovitis at initial evaluation (pre-treatment):				
1. Juvenile Idiopathic Arthritis Number of articulations with active synovitis at initial evaluation (pre-treatment):	Da	te of initial evaluation (pre-treatment):(mm/dd/y	Date of most recer	nt evaluation: (mm/dd/yyyy)
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C-reactive protein value (mg/L): Sedimentation rate value (mm/h): Score in the Childhood Health Assessment Questionnaire (CHAQ): Number of affected joints with limitation of			<u> </u>	
Score in the Childhood Health Assessment Questionnaire (CHAQ): Number of affected joints with limitation of				
Questionnaire (CHAQ): Number of affected joints with limitation of	-	Sedimentation rate value (mm/h):		
<u> </u>				
Improvement noted in the overall assessment (visual analogue scale) by: the physician the patient the parent		Improvement noted in the overall assessment (visual	al analogue scale) by:	☐ the patient ☐ the parent
Back to school, if applicable (date): Yes No () (mm/dd/yyyy)				•

3 SPECIALTY DRUG INFORMATION		
	ID N I	
Policy Number:	ID Number:	
C Renewal Request		
Please provide information on the evolution of	of the disease to evaluate the response to treat	tment
Date of initial evaluation (pre-treatment):	(mm/dd/yyyy) Date of most recent	evaluation:(mm/dd/yyyy)
2. Rheumatoid Arthritis		
Number of articulations with active synovitis at initial evaluation (pre-treatment	Number of articulat): synovitis at most re	ions with active cent 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:		
Psoriatic Arthritis Number of articulations with active	No () (mm/dd/yyyy) Number of articulat	ions with active
synovitis at initial evaluation (pre-treatment		cent evaluation:
ACR Score:		
Other items, if initially measured	Initial result	Most recent result
Score in the Health Assessment Questionnaire (HAQ):		
BASDAI Score :		
Back to work, if applicable (date):	□ No ()	
BD Additional Information		
Please indicate any additional information	rpertaining to unstequest	





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.