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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 <u>entire</u> 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: <a href="www.medaviebc.ca/en/resources">www.medaviebc.ca/en/resources</a>, 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 <a href="https://www.medaviebc.ca">www.medaviebc.ca</a> or call 1-800-667-4511.
Signature of Patient:	<b>Date:</b>

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:					_
3A Patient Support Program (PS Is patient enrolled in the Patient Su Indicate the name of the Patient Su	pport Program?				
PSP phone #:					_
Product Name	Strength	Dosage		Diagnosis	
PRALUENT (ALIROCUMAB)					
Patient weight: Expected duration of therapy: Where is medication being admini Indicate the specialty of the physic	stered?		Was treatment initiated ir		- - -
For Initial Request, please compl	ete Section 3B. Fo	r Renewals, pleas	se complete Section 3C		
3B Initial Request  Is the drug being prescribed a *NOTE: Do not provide genetic test  Date of diagnosis:  (mm/dd/yy)  Written confirmation of diagnosis	results //y)	Date of beg	inning of treatment:		
Patient's LDL-C score at the mo	_				
*** Must attach a recent treated					
1. Hyperlipidemia in a patient	with clinically evic	lent atherosclero	tic cardiovascular disea	ase (ASCVD)	
Indicate the atherosclerotic can  Coronary heart disease. If s  Acute coronary s  History of myoca  Stable or unstab  Coronary or othe	selected, please also syndrome rdial infarction (MI) le angina er arterial revascular	o select one of the	following:		
☐ Peripheral arterial disease					

3	SPECIALTY DRUG INFORMATION
	me of patient: Date of Birth : icy Number: ID Number:
3	Initial Request (cont'd)
<u>2</u> .	Heterozygous familial hypercholesterolemia (HeFH)
	Diagnosis confirmed by genetic testing: ☐ Yes ☐ No *NOTE: Do not provide genetic test results
	HeFH associated with atherosclerotic cardiovascular disease: ☐ Yes ☐ No
	Family history Is tendon xanthomas present:
	<ul> <li>☐ In patient ☐ In 1<sup>st</sup> degree relative ☐ In 2<sup>nd</sup> degree relative ☐ Not present</li> <li>☐ Other. Specify:</li> </ul>
	Presence of family history of myocardial infarction (MI):  Before the age of 60 in a 1 <sup>st</sup> degree relative Before the age of 50 in a 2 <sup>nd</sup> degree relative No family history of MI  Other. Specify:
	Presence of family history of total cholesterol concentration:
	☐ > 7.5 mmol/L in an adult relative: ☐ of 1 <sup>st</sup> degree ☐ of 2 <sup>nd</sup> degree ☐ Other. Specify:
	☐ > 6.7 mmol/L in a relative of the less than 16 years of age: ☐ of 1 <sup>st</sup> degree ☐ of 2 <sup>nd</sup> degree ☐ Other. Specify:
	Presence of familiy history of LDL-C concentration:
	□ ≥ 4.9 mmol/L in an adult relative:   □ of 1 <sup>st</sup> degree  □ of 2 <sup>nd</sup> degree     □ Other. Specify:   □
	$\Box$ ≥ 4.0 mmol/L in a relative of less than 18 years of age: $\Box$ of 1 <sup>st</sup> degree $\Box$ of 2 <sup>nd</sup> degree $\Box$ Other. Specify:
	Presence of a corneal arcus before age 45:  ☐ In 1 <sup>st</sup> degree relative ☐ In 2 <sup>nd</sup> degree relative ☐ Not present ☐ Other. Specify:
	Presence of a mutation, causing a familial hypercholesterolemia, of the LDLR, ApoB or PCSK9 genes*: *NOTE: Do not provide genetic test results  In 1 <sup>st</sup> degree relative In 2 <sup>nd</sup> degree relative Not present Other. Specify:
	Presence of family history of heterozygous familial hypercholesterolemia (HeFH):  ☐ In 1 <sup>st</sup> degree relative ☐ In 2 <sup>nd</sup> degree relative ☐ Not present ☐ Other. Specify:

3 SPECIALTY DRUG INFO	RMATION		
Name of patient:		Date of Birth :	
Policy Number:		ID Number:	
3B Initial Request (cont'd)			
and adherent to a maximum opatient intolerance (including	dose of a statin the predisposir	is statin medication history in the table below. Indicate if they are cumedication. If the statin medication dose is not maximized, pleaseing factors that have been ruled out) or contraindication document at a lower dose or lower intensity statin.	provide details of
Statin	Dose maximized? YES / NO	If NO, provide details of intolerance and the predisposing factors ruled out <b>or</b> contraindications	Re-challenge at a lower dose? YES / NO
Name :		☐ Intolerance ► ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify:	
Dose :	Yes 🗌 Yes	☐ Contraindication ▶ ☐ Pregnancy	☐ Yes
Duration :	□ No	☐ Nursing ☐ Active liver disease ☐ Other. Specify:	□ No
Name :		☐ Intolerance ► ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify:	
Dose :	Yes	☐ Contraindication ► ☐ Pregnancy	☐ Yes
Duration :	□No	☐ Nursing ☐ Active liver disease ☐ Other. Specify:	□ No
Name :		☐ Intolerance ► ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify:	
Dose :	Yes	☐ Contraindication ► ☐ Pregnancy	☐ Yes
Duration :	□No	☐ Nursing ☐ Active liver disease ☐ Other. Specify:	□ No
Name :		☐ Intolerance ► ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify:	
Dose :	Yes	☐ Contraindication ► ☐ Pregnancy	☐ Yes
Duration :	□No	☐ Nursing ☐ Active liver disease ☐ Other. Specify:	□ No
If the patient shows signs of predisposing factors:	statin intoleranc	e, please confirm that the following conditions have ben ruled out as	s possible
Untreated hypothyroidism		Biliary obstruction Yes No	
Acute renal failure  Drug interactions	<del>_</del>	Febrile illness	

3 SPECIALTY DRUG INFORM	MATION
-	Date of Birth :
Policy Number:	ID Number:
3B Initial Request (cont'd)	
Please detail patient's other (pre	evious) treatment history in the table below.
Medications	Patient response to treatment (If discontinued, provide details of intolerance, contraindication, or failure)
Ezetimib	
Dose :	
Duration :	
Fibrate	
Dose :	
Duration :	
Other sequestrant. Name:	
Dose :	
Duration :	
Other. Name of medication:	
Dose :	
Duration :	
Other. Name of medication:	
Dose :	
Duration :	
Burdion :	
3C Renewal Request  Please provide information on t	he evolution of the disease to evaluate the response to treatment
Date of initial evaluation (pre-trea	atment): Date of most recent evaluation: (mm/dd/yyyy)
*** Please attach a recent treate	d LDL cholesterol rate report to this request (within 3 months) ***





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.