MEDAVIE BLUE CROSS™

PRIOR AUTHORIZATION REQUEST

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.

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

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1 PHARMACY INFORMATION

This section is to be completed by the Professional coordinating the request on behalf of the member (PSP, Cancer Care Navigator or Pharmacy)

Decision communication preference: ☐ Fax, Number: _____ ☐ Telephone, Number: _____

Name of Program/Pharmacy: _____

Contact Name: _____ Contact E-mail: _____

2 PATIENT INFORMATION

Part A

Patient Name: _____ Date of Birth: _____ (mm/dd/yyyy)

E-mail address of patient (or of legal guardian if patient is underage): _____

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 already submitted your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt. Date: _____ (mm/dd/yyyy)

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 form)

If the patient is a dependent, provide the birth day and month of the cardholder for the other carrier: _____ (mm/dd)

Public-Funded Program – Have you applied for coverage through a public-funded program? ☐ Yes ☐ No

If No, please indicate why: _____

Part C – Authorization

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at **www.medaviebc.ca.**

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at www.medaviebc.ca or call 1-800-667-4511.

Signature of Patient: **Date:** _____ (mm/dd/yyyy)

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3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3A Patient Support Program (PSP) Enrollment – Mandatory

Is patient enrolled in the Patient Support Program? ☐ No ☐ Yes, specify Program ID #: _____

Indicate the name of the Patient Support Program: _____

PSP phone #: _____ PSP Fax #: _____

Product Name	Strength	Dosage	Diagnosis
REPATHA (EVOLOCUMAB)			

Patient weight: _____ ☐ lbs ☐ kg Number of vials per dose: _____

Expected duration of therapy: _____ Was treatment initiated in hospital? ☐ Yes ☐ No

Where is medication being administered? _____

Indicate the specialty of the physician who initiated or recommended the treatment: _____

For Initial Request, please complete Sections 3B and 3C. For Renewals, please complete Section 3D.

3B Initial Request

Is the drug being prescribed according to the Health Canada product monograph? ☐ Yes ☐ No

Date of diagnosis: _____ (mm/dd/yyyy) **Date of beginning of treatment:** _____ (mm/dd/yyyy)

Written confirmation of diagnosis from a specialist: ☐ No ☐ Yes, attach confirmation

Patient's LDL-C score at the moment of diagnosis / <u>prior</u> to any treatment: _____ **mmol/L**

Patient's baseline LDL-C score prior to treatment with Repatha (while on statins and / or ezetimib): _____ **mmol/L**

*** **Must attach a recent treated LDL cholesterol score report to this request (within 3 months)** ***

1. **Hyperlipidemia in a patient with clinically evident atherosclerotic cardiovascular disease (ASCVD)**

Indicate the atherosclerotic cardiovascular disease manifestations:

☐ Coronary heart disease. If selected, please also select one of the following:

- ☐ Acute coronary syndrome
- ☐ History of myocardial infarction (MI)
- ☐ Stable or unstable angina
- ☐ Coronary or other arterial revascularisation

☐ Cerebral disease – stroke or transient ischemic attack

☐ Peripheral arterial disease (including abdominal aortic aneurysm)

*** *Please, also answer questions in section 3C, if applicable* ***

2. **Homozygous familial hypercholesterolemia (HoFH)**

Is tendon xanthomas present in patient?
- ☐ Yes, before age of 10 (attach evidence)
- ☐ Yes, at the age of 10 or after (attach evidence)
- ☐ No

Is there evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents?
- ☐ Yes (attach evidence)
- ☐ No

*** *Please, also answer questions in section 3C, if applicable* ***

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3B Initial Request (cont'd)

3. **Heterozygous familial hypercholesterolemia (HeFH)**

HeFH associated with atherosclerotic cardiovascular disease: ☐ Yes ☐ No

Family history

Is tendon xanthomas present?

☐ In patient ☐ In 1st degree relative ☐ In 2nd degree relative ☐ Not present

☐ Other. Specify: _____

Presence of family history of myocardial infarction (MI)?

☐ Before the age of 60 in a 1st degree relative ☐ Before the age of 50 in a 2nd 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 1st degree ☐ of 2nd degree

☐ Other. Specify: _____

☐ > 6.7 mmol/L in a relative of the less than 16 years of age: ☐ of 1st degree ☐ of 2nd degree

☐ Other. Specify: _____

Presence of familiy history of LDL-C concentration:

☐ ≥ 4.9 mmol/L in an adult relative: ☐ of 1st degree ☐ of 2nd degree

☐ Other. Specify: _____

☐ ≥ 4.0 mmol/L in a relative of less than 18 years of age: ☐ of 1st degree ☐ of 2nd degree

☐ Other. Specify: _____

Presence of a corneal arcus before age 45:

☐ In 1st degree relative ☐ In 2nd 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 1st degree relative ☐ In 2nd degree relative ☐ Not present

☐ Other. Specify: _____

Presence of family history of heterozygous familial hypercholesterolemia (HeFH):

☐ In 1st degree relative ☐ In 2nd degree relative ☐ Not present

☐ Other. Specify: _____

*** *Please, also answer questions in section 3C, if applicable* ***

3 SPECIALTY DRUG INFORMATION

Name of patient: ______________________ Date of Birth : ______________

Policy Number: ______________________ ID Number: ______________

3C Initial Request (cont'd) – General clinical information

Please detail the patient's current and previous statin medication history in the table below. Indicate if they are currently prescribed and adherent to a maximum dose of a statin medication. If the statin medication dose is not maximized, please provide details of patient intolerance (including the predisposing factors that have been ruled out) or contraindication documentation. Please also indicate if there has been a statin re-challenge at a lower dose or lower intensity statin.

Statin	Dose maximized? YES / NO	If NO, provide details of intolerance and the predisposing factors ruled out **or** contraindications	Re-challenge at a lower dose? YES / NO
Name : ______ Dose : ______ Duration : ______	☐ Yes ☐ No	☐ Intolerance ▶ ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify: ______ ☐ Contraindication ▶ ☐ Pregnancy ☐ Nursing ☐ Active liver disease ☐ Other. Specify: ______	☐ Yes ☐ No
Name : ______ Dose : ______ Duration : ______	☐ Yes ☐ No	☐ Intolerance ▶ ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify: ______ ☐ Contraindication ▶ ☐ Pregnancy ☐ Nursing ☐ Active liver disease ☐ Other. Specify: ______	☐ Yes ☐ No
Name : ______ Dose : ______ Duration : ______	☐ Yes ☐ No	☐ Intolerance ▶ ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify: ______ ☐ Contraindication ▶ ☐ Pregnancy ☐ Nursing ☐ Active liver disease ☐ Other. Specify: ______	☐ Yes ☐ No
Name : ______ Dose : ______ Duration : ______	☐ Yes ☐ No	☐ Intolerance ▶ ☐ Myositis ☐ Rhabdomyolysis ☐ Other. Specify: ______ ☐ Contraindication ▶ ☐ Pregnancy ☐ Nursing ☐ Active liver disease ☐ Other. Specify: ______	☐ Yes ☐ No
☐ No previous treatment	n/a	n/a	n/a

If the patient shows signs of statin intolerance, please confirm that the following conditions have ben ruled out as possible predisposing factors:

Untreated hypothyroidism … ☐ Yes ☐ No
Acute renal failure ………….. ☐ Yes ☐ No
Drug interactions …………… ☐ Yes ☐ No
Biliary obstruction ….. ☐ Yes ☐ No
Febrile illness ………. ☐ Yes ☐ No
Alcoholism ………….. ☐ Yes ☐ No

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3C Initial Request (cont'd) – General clinical information

Please detail patient's other (previous) treatment history in the table below.

Medications	Patient response to treatment (If discontinued, provide details of intolerance, contraindication, or failure)
Ezetimib Dose : _____ Duration : _____	In association with evolocumab : ☐ Yes ☐ No ☐ Inefficient ☐ Intolerance ☐ Contraindication ☐ Other Specify: _____
Fibrate Dose : _____ Duration : _____	In association with evolocumab : ☐ Yes ☐ No ☐ Inefficient ☐ Intolerance ☐ Contraindication ☐ Other Specify: _____
Other sequestrant. Name: _____ Dose : _____ Duration : _____	In association with evolocumab : ☐ Yes ☐ No ☐ Inefficient ☐ Intolerance ☐ Contraindication ☐ Other Specify: _____
Other. Name of medication: _____ Dose : _____ Duration : _____	In association with evolocumab : ☐ Yes ☐ No ☐ Inefficient ☐ Intolerance ☐ Contraindication ☐ Other Specify: _____
Other. Name of medication: _____ Dose : _____ Duration : _____	In association with evolocumab : ☐ Yes ☐ No ☐ Inefficient ☐ Intolerance ☐ Contraindication ☐ Other Specify: _____

3D 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)

***** Please attach a recent treated LDL cholesterol rate report to this request (within 3 months) *****

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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 requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit.

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