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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



patient enrolled in the Patient Supp dicate the name of the Patient Supp SP phone #: Product Name) Enrollment port Program? port Program:	No ☐ Yes, sp	ID Number:			
dicate the name of the Patient Supp SP phone #: Product Name	oort Program? oort Program:	-				
dicate the name of the Patient Supp SP phone #: Product Name	oort Program:	-				
SP phone #: Product Name			• •			
Product Name						
	SP phone #: PSP Fax #:					
	Strength	Dosage		Diagnosis		
REVOLADE (ELTROMBOPAG)						
Patient weight:] lbs □ kg		Number of vials per dos	e:		
Expected duration of therapy:			Date of diagnosis: ——	(mm/dd/yyyy)		
Was treatment initiated in hospital?	☐ Yes ☐ No			(піп/аа/уууу)		
Where is medication being administe						
Indicate the specialty of the physicia	n who initiated or	recommended t	the treatment:			
	0ti 0D. F	D		•		
or Initial Request, please complet	e Section 3B. Fo	r Kenewais, pi	ease complete Section 3	C.		
B Initial Request						
lease list all the drugs that were p rug categories (relative to each di				ndication. The information for the follow traindication if applicable.		
		-	-	•		
 Chronic idiopathic thrombocytope Severe aplastic anemia: antithymo 				ravenous anti-D		
Category Product	t Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication		
NOTE: Do not provide genetic test re	esults	lealth Canad	a product monograph	? □ Yes □ No		
NOTE: Do not provide genetic test re	esults	Health Canad	a product monograph	? □ Yes □ No		
NOTE: Do not provide genetic test re	esults Canada:		a product monograph	? □ Yes □ No		
NOTE: Do not provide genetic test re	esults <u>Canada</u> : ytopenic purpura	1	a product monograph	? □Yes □No		
pproved indications from Health (Chronic idiopathic thromboc Indicate if the patient is splenectors	esults Canada: ytopenic purpura pmized: ☐ Yes	l □ No				
pproved indications from Health (Chronic idiopathic thromboc Indicate if the patient is splenector	esults Canada: ytopenic purpura pmized: ☐ Yes	l □ No		? □Yes □No		
NOTE: Do not provide genetic test respectively. **Poper of the patient is splenected by the real specific test respectively. **If no, specify test respectively. **I	Canada: ytopenic purpura pmized: Yes ason preventing the	ı □ No e surgery (spler	nectomy):			
Indicate if the patient is splenector	esults Canada: ytopenic purpura omized: Yes ason preventing the	l □ No e surgery (spler globulin treatme	nectomy): nt was initiated, if applicat			

	•	Date of Birth :
Ро	licy Number:	ID Number:
В	Initial Request (cont'd)	
2.	Severe aplastic anemia	
	Bone marrow cellularity :	%
	Absolute neutrophil count :	/μL
	Absolute reticulocytes :	x 10³/µL
	Platelet count :	x 10³/µL
3.	Hepatitis C Virus (HCV) related thro	ombocytopenia
	Indicate if the degree of the thrombocyte	openia prevents the initiation of interferon-based therapy
	and/or limits the ability to maintain inter	feron-based therapy:
	Indicate if a pegylated interferon and rib	pavirin therapy for treatment of HCV has been prescribed:
	Indicate the duration of the interferon ba	ased therapy:
	Baseline ALT level (date):	()
	Current ALT level (date):	(
	Indicate if the patient has (select all that app	
	☐ A normal liver function	
	☐ Elevations in transaminases before t	treatment and they are:
	→ □ progressive	
	persistent for 4 weeks of	or more
	accompanied by increas	sed direct bilirubin
	☐ accompanied by clinical	symptoms of liver injury or evidence for hepatic decompensation
	Child-Pugh class score:	
4.	Please indicate any additional infor	rmation pertaining to this request:
	Renewal Request	
	•	on of the disease to evaluate the response to treatment
)a	te of initial evaluation (pre-treatment): _	Date of most recent evaluation: (mm/dd/yyyy)
	Chronic idiopathic thrombocytopen	nic purpura
	Platelet count (prior to treatment) :	x 10 ⁹ /L
	Platelet count (most recent value):	
		has been administrated as part of rescue therapy: ☐ Yes ☐ No

3	SPECIALTY DRUG INFORMATION
Na	me of patient: Date of Birth :
Ро	licy Number: ID Number:
3C	Renewal Request (cont'd)
2.	Severe aplastic anemia
	Please provide information describing the beneficial clinical response to treatment
3.	Hepatitis C Virus (HCV) related thrombocytopenia
	Indicate if the degree of the thrombocytopenia prevents the initiation of interferon-based therapy
	Indicate if a pegylated interferon and ribavirin therapy for treatment of HCV has been prescribed: Yes No
	Indicate the duration of the interferon based therapy:
	Baseline ALT level (date): ()
	Current ALT level (date): ()
	Indicate if the patient has (select all that apply):
	☐ A normal liver function
	☐ Elevations in transaminases before treatment and they are:
	→ □ progressive
	persistent for 4 weeks or more
	accompanied by increased direct bilirubin
	accompanied by clinical symptoms of liver injury or evidence for hepatic decompensation
	Child-Pugh class score:
4	
4.	Please provide information describing the beneficial clinical response to treatment
_	
5.	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)

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No.