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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 Medavie Blue Cross, please indicate the date of the oldest receipt the o	
Part B – Coordination of Benefits	· · · · · · · · · · · · · · · · · · ·
Do you or any dependant have coverage for this drug under any other plan of	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	er 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 lucts 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 ring 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 discl providers 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 consents are complied to the consent complied to the consent complied with federal consents.	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 ral and provincial privacy laws.
For more details about our information practices, including how your person you have concerns or questions, please see our Medavie Blue Cross Privacy	al information is protected, how to access or correct personal information, or if 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 INFORMATION				
Name of patient: Date of Birth:				
•	Policy Number: ID Number:			
E-mail address of patient or of leg	al guardian if patient	is underage:		
3A Patient Support Program (PS	SP) Enrollment			
Is patient enrolled in the Patient Sup	oport Program? 🔲	No 🗌 Yes, speci	fy Program ID #:	
Indicate the name of the Patient Su	··			
PSP phone #:			PSP Fax #:	
Product Name	Strength	Dosage		Diagnosis
RINVOQ (UPADACITINIB)				
Patient weight:	☐ lbs ☐ kg	Number of	vials / syringes per dos	se:
Date treatment was initiated:		E	xpected duration of tre	eatment:
Date of diagnosis:	(mm/dd/yyyy)	V	Vas treatment initiated	in hospital? ☐ Yes ☐ No
(mm, Where is medication being admini	'dd/yyyy) stered?			
•				
Indicate if the disease or injury is v	vork related: 🔲 Ye	es 🗌 No		
For Initial Request, please compl	ete sections 3B an	d 3D. For Renewa	s, please complete s	ections 3C and 3D.
3B Initial Request				
				ndications. The information for the on the contraindication if applicable.
- Rheumatoid Arthritis: DMARDs,	•			
Psoriatic Arthritis: DMARDs, meAtopic Dermatitis: phototherapy	•			agent
- Ankylosing Spondylitis: advanced	· ·		entonurino	
	Ulcerative Colitis: advanced treatment, prednisone, azathioprine, 6-mercaptopurine Crohn's Disease: advanced treatment, glucocorticoids, conventional immunosuppressants (azathioprine, 6-mercaptopurine, methotrexate)			
Category Prod	uct Name	Dosage D	uration of Treatment	Response to Treatment or Contraindication
Is the drug being prescribed according to the Health Canada product monograph? ☐ Yes ☐ No *NOTE: Do not provide genetic test results.				s □ No
Approved indications from Health Canada:				
1. Rheumatoid Arthritis				
Moderate to severely active disease: ☐ Yes ☐ No Rheumatoid factor: ☐ Positive ☐ Negative				
Number of articulations with active synovitis: Radiologically measured erosions: Yes No				
Confirm all that are applicable	(prior to treatment):			
☐ C-reactive protein level:			☐ CDAI Score	:
☐ Sedimentation rate:			☐ HAQ Score:	

Date of Birth:	3	SPECIALTY DRUG INFORMATION	
Initial Request (cont'd) Psoriatic Arthritis Reumatoid type		•	
Initial Request (cont'd) Psoriatic Arthritis Rheumatoid type		•	
Psorlatic Arthritis Rheumatoid type	11	nali address of patient of of legal guardian if patient is	underage.
Rheumatoid type		Initial Request (cont'd)	
Peripheral Psoriatic Arthritis		Psoriatic Arthritis	
Number of articulations with active synovitis: Radiologically measured erosions: No Confirm all that are applicable (prior to treatment):		☐ Rheumatoid type	☐ Type other than rheumatoid
Confirm all that are applicable (prior to treatment): C-reactive protein level: mg/L		☐ Peripheral Psoriatic Arthritis	☐ Axial Psoriatic Arthritis
C-reactive protein level: mg/L		Number of articulations with active synovitis:	Radiologically measured erosions: Yes No
Sedimentation rate: mm/h		Confirm all that are applicable (prior to treatment):	
Does the patient also have moderate to severe psoriasis?		C-reactive protein level: mg/L	BASDAI Score :
If yes, please provide the following information: PASI Score: Percentage of body surface area affected :		Sedimentation rate: mm/h	☐ HAQ Score:
PASI Score:		Does the patient also have moderate to severe psoria	asis? 🗌 Yes 🔲 No
Atopic dermatitis EASI Score:		If yes, please provide the following information:	
Atopic dermatitis EASI Score:		PASI Score: Pe	rcentage of body surface area affected : %
EASI Score:		Presence of large plaques (location):	
Physician's Global Assessment (PGA) score: Description of the physician's Global Assessment (PGA) score: Description of the physician's Global Assessment (PGA) score: Description of treatment (in months): Physician's Global Assessment (PGA) score: Description of treatment (in months): Description of treatment (in months):	3.	•	DLQI or cDLQI Score :
Physician's Global Assessment (PGA) score: \[0 - \text{No inflammatory signs of atopic dermatitis} \] \[1 - \text{Just perceptible erythema and papulation} \] \[2 - \text{Mild erythema and papulation} \] \[3 - \text{Moderate erythema and papulation} \] \[4 - \text{Severe erythema papulation} \] \[5 - \text{Severe erythema papulation with oozing / crusting} \] \[\text{Is phototherapy treatment indicated and accessible?} \] \[\text{Yes} \] \[\text{No} \] \[\text{Failure to phototherapy:} \] \[\text{Yes} \] \[\text{No} \] \[\text{Number of sessions:} \] \[\text{Duration of treatment (in months):} \] \[\text{Duration of treatment (in months):} \]		Peak Pruritus NRS Score:	Percentage of body surface area affected : %
□ 0 – No inflammatory signs of atopic dermatitis □ 1 – Just perceptible erythema and papulation □ 3 – Moderate erythema and papulation □ 4 – Severe erythema papulation □ 5 – Severe erythema papulation with oozing / crusting Is phototherapy treatment indicated and accessible? □ Yes □ No Failure to phototherapy: □ Yes □ No Number of sessions: □ Duration of treatment (in months): □		Presence of large plaques (location):	
□ 2 – Mild erythema and papulation □ 3 – Moderate erythema and papulation □ 4 – Severe erythema papulation □ 5 – Severe erythema papulation with oozing / crusting Is phototherapy treatment indicated and accessible? □ Yes □ No Failure to phototherapy: □ Yes □ No Number of sessions: □ Duration of treatment (in months):		Physician's Global Assessment (PGA) score:	
☐ 4 – Severe erythema papulation ☐ 5 – Severe erythema papulation with oozing / crusting Is phototherapy treatment indicated and accessible? ☐ Yes ☐ No Failure to phototherapy: ☐ Yes ☐ No Number of sessions: ☐ Duration of treatment (in months): ☐ ☐		☐ 0 – No inflammatory signs of atopic dermatitis	☐ 1 – Just perceptible erythema and papulation
Is phototherapy treatment indicated and accessible?		2 – Mild erythema and papulation	☐ 3 – Moderate erythema and papulation
Failure to phototherapy: Yes No Number of sessions: Duration of treatment (in months):		☐ 4 – Severe erythema papulation	☐ 5 – Severe erythema papulation with oozing / crusting
		Is phototherapy treatment indicated and accessible?	☐ Yes ☐ No
Indicate why the phototherapy treatment had to be stopped:		Failure to phototherapy: Yes No Number	er of sessions: Duration of treatment (in months):
		Indicate why the phototherapy treatment had to be sto	opped:

3	SPECIALTY DRUG INFORMATION	
	me of patient:	
	licy Number: ID	
E-r	mail address of patient or of legal guardian if patient is underage:	
В	Initial Request (cont'd)	
4.	Ankylosing Spondylitis	
	Axial form: Yes No Radiographic: Yes	No
	□ BASDAI Score : □ HAQ Score:	
	If applicable, please indicate the reason why another biologic treatment	is contraindicated:
5.	Ulcerative Colitis	
	Mayo Score:	Partial Mayo Score:
	Mayo endoscopic subscore:	
6.	Crohn's Disease	
	HBI Score:	CDAI Score:
	Does the patient have actively draining perianal or enterocutaneous fist despite a course of appropriate antibiotic therapy and immunosuppress	□ Ves □ No
Specify the antibiotic and immunosuppressive therapy used:		
	Presence of one of the following features for high-risk (if applicable):	
	☐ Elevated C-reactive protein and / or fecal calprotectin levels	☐ Deep ulcers on colonoscopy
	Long segments of small and / or large bowel involvement	☐ Perianal disease
	Extra-intestinales manifestations	☐ History of bowel resections
	Has the patient required hospitalization for severe symptoms? ☐ Yes	□ No
	Specify the symptoms:	

3 SPECIALTY DRUG INFORMATION		
Name of patient:		
Policy Number:		
E-mail address of patient or of legal guardian if pa	itient is underage:	
BC Renewal Request		
Please provide information on the evolution of t	the disease to evaluate the response to treatm	nent
Date of initial evaluation (pretreatment):	Date of most recent e	valuation:(mm/dd/yyyy)
1. Rheumatoid Arthritis		
Number of articulations with active synovitis at initial evaluation (pre-treatment): _	Number of articulation synovitis at most rece	ns with active ent 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 synovitis at initial evaluation (pre-treatment):	Number of articulation synovitis at most rece	ns with active ent 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):		
BASDAI Score :		
Back to work, if applicable (date):] No () (mm/dd/yyyy)	

3	SPECIALTY DRUG INFORMATION			
	Name of patient: Date of Birth:			
	Policy Number: ID Number:			
<u>E</u> -	E-mail address of patient or of legal guardian if patient is underage:			
3C	Renewal Request (cont'd)			
Ple	ase provide information on the evolution of	the disease to evaluate the response to trea	atment	
Da	ate of initial evaluation (pretreatment):	Date of most recen	t evaluation:(mm/dd/yyyy)	
	,		(
3.	Atopic dermatitis			
	Recent Physician's Global Assessment (PGA) score:		
	☐ 0 – No inflammatory signs of atopic derma	titis ☐ 1 – Just perceptib	ole erythema and m	
	☐ 2 – Mild erythema and papulation		thema and papulation	
	☐ 4 – Severe erythema papulation	☐ 5 – Severe erythe	ema papulation with oozing / crusting	
			Deculto et mant manut avaluation	
		Results at initial or previous evaluation	Results at most recent evaluation (current)	
	EASI Score :			
	DLQI or cDLQI Score :			
	Percentage of body surface area affected:	%	%	
	Peak Pruritus NRS Score:			
4.	Ankylosing Spondylitis			
	Item initially measured	Initial result	Most recent result	
	BASDAI Score :			
	Score in the Health Assessment Questionnaire (HAQ):			
	Back to work, if applicable (date):			
		(mm/dd/yyyy)		

3 SPECIALTY DRUG INFORMATION				
Name of patient:		Date of Birth:		
Policy Number:	ID Number:			
E-mail address of patient or of legal guardiar	n if patient is underage:			
3C Renewal Request (cont'd)	3C Renewal Request (cont'd)			
Please provide information on the evolutio	n of the disease to evaluate the response to tre	atment		
Date of initial evaluation (pretreatment):	(mm/dd/yyyy) Date of most rece	nt evaluation:(mm/dd/yyyy)		
5. Ulcerative Colitis				
Medical assessment	Result at initial evaluation	Result at most recent evaluation		
Mayo Score:				
Partial Mayo Score:				
Mayo endoscopic subscore:				
HBI Score at initial evaluation (pretreatme		Score (current):		
3D Additional Information				
Please indicate any additional informati	on pertaining to this request			





i HEALTH PROFESSIONAL	STATEMENT	
I certify that I have reviewed al	I pages of this request and that all informa	tion 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 reform may be subject to audit.	equested information in detail to help avoid	(mm/dd/yyyy) d delay in assessing claims for the above drug. This

Residents of All Other Provinces
PO BOX 220, MONCTON (NB) E1C 8L3
TEL.: 1-800-667-4511 FAX: 1-844-661-2640

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