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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



3 SPECIALTY DRUG INF	ORMATION			
Name of patient:				Date of Birth :
Policy Number:				
E-mail address of patient or	of legal guardian if patient	t is underage:		
3A Patient Support Progra	m (PSP) Enrollment			
•	* *	=	· ·	
Indicate the name of the Patie				
PSP phone #:			PSP Fax #:	
Product Name	Strength	Dosage		Diagnosis
VASCEPA (ICOSAPENT ETHY	YL)			
Patient weight:	□ lbs □ kg		Number of vials per do	se:
Date treatment was initiated:	(mm/dd/yyyy)		Expected duration of tr	eatment:
Date of diagnosis:			Was treatment initiated	in hospital? ☐ Yes ☐ No
Where is medication being a	(mm/dd/yyyy)			
_			treatment:	
Indicate if the disease or inju				
For Initial Possess along	amulata agationa 2D an	4 20		
For Initial Request, please of 3B Initial Request	omplete sections 35 an	u 3C.		
•	wore proviously tried o	or could not be tr	ind because of contra	indication. The information for the following
drug categories (relative to - Reduce the risk of cardiov	each diagnosis) must be			
Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication
Is the drug being prescribed *NOTE: Do not provide genetic te	est results	h Canada produc	t monograph? 🔲 Ye	es 🗌 No
Approved indications from He	alth Canada:			
1. To reduce the risk of	cardiovascular events			
Is the patient currently or	n a statin therapy at maxin	num tolerated dos	e for at least 4 weeks?	☐ Yes ☐ No
Fasting triglyceride level	within the last 12 months	:	mmol/L	
LDL cholesterol level :_		_ mmol/L		
Non-HDL cholesterol lev	rel :	mmol/L		
Does the patient have dia	abetes that requires insuli	n or medication?	☐ Yes ☐ No	

3	SPECIALTY DRUG INFORMATION					
Na	ame of patient:	Date of Birth :				
	olicy Number: ID Number:	<u> </u>				
E-ı	-mail address of patient or of legal guardian if patient is underage:					
3B						
1.	To reduce the risk of cardiovascular events (cont'd)					
	Does the patient have an established cardiovascular disease? ☐ Yes ☐ No					
	Medical history:					
	☐ Acute coronary syndrome (ACS)					
	☐ Myocardial infarction (MI)					
	☐ Stable or unstable angina					
	☐ Coronary artery disease documented using angiography					
	Coronary or other arterial revascularization (coronary artery bypass graft surgery, femoral popularization)	oliteal bypass graft surgery, etc)				
	Stroke					
	☐ Transient ischemic attack					
	Documented carotid disease					
	☐ Peripheral artery disease					
	☐ Abdominal aortic aneurysm					
	Risk factors for cardiovascular disease:					
	☐ Cigarette smoker or stopped smoking in the last 3 months					
	☐ Hypertension or on antihypertensive medication					
	☐ HDL cholesterol level of 1 mmol/L or lower for men or 1.3 mmol/L or lower for women					
	☐ High-sensitivity C-reactive Protein (Hs-CRP) above 3.00 mg/L					
	Renal dysfunction: creatinine clearance (CrCL) above 30 and below 60 mL/min					
	Retinopathy					
	☐ Microalbuminuria or macroalbuminuria					
	☐ Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication					
3C	Additional Information					
	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.