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

MEDAVIE BLUE CROSS™

PRIOR AUTHORIZATION REQUEST

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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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 legal guardian if patient is underage: ______________________

3A Patient Support Program (PSP) Enrollment

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
VYNDAMAX (TAFAMIDIS)			

Patient weight: ____________ ☐ lbs ☐ kg Number of vials / syringes per dose: ______________

Date treatment was initiated: ______________ (mm/dd/yyyy) Expected duration of treatment: ______________

Date of diagnosis: ______________ (mm/dd/yyyy) Was treatment initiated in hospital? ☐ Yes ☐ No

Where is medication being administered? ______________________

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

Indicate if the disease or injury is work related: ☐ Yes ☐ No

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

3B Initial Request

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

*NOTE: Do not provide genetic test results.

Approved indications from Health Canada:

1. **Transthyretin amyloidosis cardiomyopathy (ATTR-CM)**

Administration of treatment:

☐ In monotherapy

☐ In combination with a disease modifying treatment for ATTR. Specify: ______________________

Confirmation of the absence of light chain amyloidosis: ☐ Yes ☐ No

Diagnosis of ATTR-CM is confirmed by:

☐ Bone scintigraphy or cardiac biopsy

☐ Genetic test **NOTE: Do not provide genetic test results.*

☐ Other. Specify: ______________________

Cardiac disease classification according to the criteria of the New York Heart Association (NYHA): ______________

Has the patient received a heart or liver transplant? ☐ Yes ☐ No

Does the patient have an implanted cardiac mechanical assist device (CMAD)? ☐ Yes ☐ No

3 SPECIALTY DRUG INFORMATION

Name of patient: ______________________ Date of Birth : ______________

Policy Number: ______________________ ID Number: ______________

E-mail address of patient or of legal guardian if patient is underage: ______________________

3B Initial Request (cont'd)

1. **Transthyretin amyloidosis cardiomyopathy (ATTR-CM) (cont'd)**

Medical history of heart failure:

☐ Previous hospitalization

☐ Clinical manifestations that required treatment with a diuretic

☐ Other. Specify: ______________________

☐ No medical history

3C Renewal Request

Please provide information on the evolution of the disease to evaluate the response to treatment

Date of initial evaluation (pretreatment): ______________ (mm/dd/yyyy) Date of most recent evaluation: ______________ (mm/dd/yyyy)

1. **Transthyretin amyloidosis cardiomyopathy (ATTR-CM) (cont'd)**

Cardiac disease classification according to the criteria of the New York Heart Association (NYHA): ______________

Has the patient received a heart or liver transplant? ☐ Yes ☐ No

Does the patient have an implanted cardiac mechanical assist device (CMAD)? ☐ Yes ☐ No

3D Additional Information

Please indicate any additional information pertaining to this request

PRIOR AUTHORIZATION REQUEST

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.