Strictly Confidential

BIOLOGIC RESPONSE MODIFIERS Prior Authorization Form

Fax completed form to 1-902-481-7114

Or Mail to: MHCSI, 201 Brownlow Avenue, Unit 20
Dartmouth, NS B3B 1W2

This form must be completed IN **FULL** and submitted to MHCSI to permit authorization for coverage of a biologic response modifier on your employer-sponsored drug plan. Coverage will be granted if criteria are met and this class of medication is a benefit of your plan. Please contact MHCSI for details of the criteria for these medications. Approvals may be subject to quantity or dollar limits as per plan design.

PATIENT INFORMATION

NAME:_____DATE OF BIRTH ___ _____
(PLEASE PRINT)

ADDRESS:_____
(STREET/MAILBOX) (CITY)

_____
(PROVINCE) (POSTAL CODE)

MHCSI CARD NUMBER:_____/_____
(GROUP #) (CERTIFICATE OR CLIENT#)

I hereby authorize my physician/nurse practitioner and/or pharmacist to provide the information necessary to complete this form on my behalf for coverage of a biologic response modifier by my drug plan.

SIGNATURE:_____ DATE:_____

TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER (NP) And/or PHARMACIST IN CONSULTATION WITH THE PHYSICIAN/NURSE PRACTITIONER

Dear Doctor/Nurse Practitioner/Pharmacist: We appreciate you providing information on this patient's medical condition and medication history which is required by the drug plan sponsor for authorization of claims for a biologic response modifier. Please complete the following sections of this form IN FULL. Any costs incurred in the completion of this form are the responsibility of the patient.

Drug Name-generic brand may be used where available		Dose / Dosing interval
☐ Simponi Pre-Filled Syringe ☐ Infliximab (Remicade) ☐ Golimumab (Simponi) ☐ Etanercept (Enbrel) 25 mg ☐ Etanercept (Enbrel) 50mg ☐ Adalimumab (Humira) ☐ Certolizumab (Cimzia) ☐ Other(please list)	DIN 02324776 DIN 02244016 DIN 02324784 DIN 02242903 DIN 02274728 DIN 02258595 DIN 02331675	
☐ Abatacept (Orencia) ☐ Rituximab (Rituxan) ☐ Anakinra (Kineret)	DIN 02282097 DIN 02241927 DIN 02245913	
Is this request for ____ initial coverage ____ continuation		

Continued on next page

INFORMATION SUPPORTING REQUIREMENT FOR THIS MEDICATION

Diagnosis

- ☐ Ankylosing Spondylitis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Crohn's Disease
- ☐ Psoriasis
- ☐ Other

Medication History

(*as pertains to disease state)*

- ☐ Methotrexate
- ☐ Sulfasalazine
- ☐ Hydroxychloroquine
- ☐ Azathioprine
- ☐ Leflunomide
- ☐ Drug combinations
- ☐ Acitretin (Soriatane)
- ☐ Cyclosporine
- ☐ Other

Outcome of Therapy

☐ Contraindication ☐ Adverse effect ☐ Therapeutic Failure ☐ Other

Please Provide details :

Additional Information Specific to Disease State

Additional information for the indication of **Psoriasis**	☐ Body Surface Area (BSA) Involvement >10 % ☐ Significant involvement of face, hands, feet or genital region ☐ Failure to respond to, intolerant of or unable to access photo therapy	
Additional information for the indication of **Ankylosing Spondylitis**	☐ BASDAI score ≥ 4 ☐ Axial symptoms ☐ Peripheral symptoms ☐ NSAID s tried _____	
Physician/NP Name/Signature:	**Phone:**	**Date:**
Pharmacist Name/Signature:	**Store # & Location/ Phone # :**	**Date:**

OFFICE USE ONLY

Approval ☐ **Accepted** ☐ **Declined**	**Date**	**Quantity**
	Approved by	**and/or End date**
Extension possible ☐ **Yes** ☐ **No**		