

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
<input type="checkbox"/> Simponi Pre-Filled Syringe	DIN 02324776
<input type="checkbox"/> Infliximab (Remicade)	DIN 02244016
<input type="checkbox"/> Golimumab (Simponi)	DIN 02324784
<input type="checkbox"/> Etanercept (Enbrel) 25 mg	DIN 02242903
<input type="checkbox"/> Etanercept (Enbrel) 50mg	DIN 02274728
<input type="checkbox"/> Adalimumab (Humira)	DIN 02258595
<input type="checkbox"/> Certolizumab (Cimzia)	DIN 02331675
<input type="checkbox"/> Other (please list)	
<input type="checkbox"/> Abatacept (Orencia)	DIN 02282097
<input type="checkbox"/> Rituximab (Rituxan)	DIN 02241927
<input type="checkbox"/> Anakinra (Kineret)	DIN 02245913
Is this request for _____ initial coverage _____ continuation	

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INFORMATION SUPPORTING REQUIREMENT FOR THIS MEDICATION

<u>Diagnosis</u>		
<input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Juvenile Rheumatoid Arthritis	<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: _____	
<u>Medication History</u> <i>(as pertains to disease state)</i>		
<input type="checkbox"/> Methotrexate <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Hydroxychloroquine <input type="checkbox"/> Azathioprine	<input type="checkbox"/> Leflunomide <input type="checkbox"/> Drug combinations <input type="checkbox"/> Acitretin (Soriatane) <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Other	
<u>Outcome of Therapy</u>		
<input type="checkbox"/> Contraindication <input type="checkbox"/> Adverse effect <input type="checkbox"/> Therapeutic Failure <input type="checkbox"/> Other		
Please Provide details :		
Additional Information Specific to Disease State		
Additional information for the indication of Psoriasis	<input type="checkbox"/> Body Surface Area (BSA) Involvement >10 % <input type="checkbox"/> Significant involvement of face, hands, feet or genital region <input type="checkbox"/> Failure to respond to, intolerant of or unable to access photo therapy	
Additional information for the indication of Ankylosing Spondylitis	<input type="checkbox"/> BASDAI score ≥ 4 <input type="checkbox"/> Axial symptoms <input type="checkbox"/> Peripheral symptoms <input type="checkbox"/> NSAIDs tried: _____	
Physician/NP Name/Signature:	Phone:	Date:
Pharmacist Name/Signature:	Store # & Location/ Phone # :	Date:
OFFICE USE ONLY		
Approval	<input type="checkbox"/> Accepted <input type="checkbox"/> Declined	Date
		Quantity
	Approved by	and/or End date
Extension possible <input type="checkbox"/> Yes <input type="checkbox"/> No		