

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: _____ (CITY)

(STREET/MAILBOX) (PROVINCE) (POSTAL CODE)

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

Coordination of benefits (COB): NO YES If yes, Name of Coordinating Plan _____

If MHCSI, please provide: _____ / _____
(GROUP #) (CERTIFICATE OR CLIENT#)

Is this drug being covered by the coordinating plan? NO YES

I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.

Signature _____ Date(YYYY/MM/DD) _____

TO BE COMPLETED BY THE MEDICAL PRACTITIONER

Dear Prescribing Medical Practitioner: 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"/> Golimumab(Simponi) Pre-Filled Syringe	DIN 02324776
<input type="checkbox"/> Golimumab (Simponi)	DIN 02324784
<input type="checkbox"/> Infliximab (Remicade)	DIN 02244016
<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"/> Tocilizumab (Actemra)	DIN 02350092
<input type="checkbox"/> Tocilizumab (Actemra)	DIN 02350106
<input type="checkbox"/> Tocilizumab (Actemra)	DIN 02350114
<input type="checkbox"/> Ustekinumab (Stelara)	DIN 02320673
<input type="checkbox"/> Other(please list)	
<input type="checkbox"/> Abatacept (Orencia)	DIN 02282097
<input type="checkbox"/> Rituximab (Rituxan)	DIN 02241927
Is this request for _____ initial coverage _____ continuation	

Continued on next page

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: _____		
Prescriber 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	Processing Number
Extension possible <input type="checkbox"/> Yes <input type="checkbox"/> No			