the co-operators
A Better Place For You®

GROUP BENEFITS
PRIOR AUTHORIZATION FORM
ELIQUIS (apixaban), PRADAXA (dabigatran)

Submit this form to: Co-operators Life Insurance Company Extended Health Care Claims 1920 College Avenue, Regina, SK S4P 1C4 or Fax to: (306) 761-7101

PART 1 - PATIENT INFORMATION

Group ______________ Account ______________ Certificate ______________

Plan Member ______________ (First Name) ____ (Initial) ______________ (Last Name) ☐ Male ☐ Female

Telephone (________) ______________

If you prefer email notification for the results of your prior authorization, please provide your email address ______________

We use reasonable safeguards to protect all information collected, used, retained and disclosed in the course of conducting business; however, email may be vulnerable to interception by unauthorized parties. We discourage you from emailing personal or sensitive information. If you provided your email to us, or if you contacted us by email, we accept this as your consent to communicate with you by email. If you do not wish for us to communicate with you by email, please notify us at your earliest convenience.

Patient ______________ (First Name) ____ (Initial) ______________ (Last Name) ☐ Male ☐ Female

Address ______________ (Street) ______________ (City) ______ (Province) ______ (Postal Code)

Date of Birth ______________ (MMM/DD/YYYY) Relationship to Plan Member ______________

PART 2 - CO-ORDINATION OF BENEFITS

In order to ensure you are receiving benefits to which you may be entitled, please answer the following questions. An incomplete response will result in processing delays.

Have you applied for coverage or received any financial assistance or other support related to this drug?

a. Under any group or individual benefit plan? ☐ Yes ☐ No

If yes, name of covered family member ______________ (First Name) ____ (Initial) ______________ (Last Name)

Relationship ______________ Name of Insurance Company ______________

Plan Number ______________ Plan Member ID Number ______________

Attach documentation of acceptance or declination and provide details including coinsurance and any applicable maximums

b. Under a provincial program? ☐ Yes ☐ No

If yes, name of provincial program ______________

If no, please explain why application has not been made ______________

Provide details and attach documentation of acceptance or declination

c. Under a patient assistance program or any other source? ☐ Yes ☐ No

If yes, name of program or other source ______________

Patient assistance program ID number ______________

Patient assistance program contact person and phone number

Contact Name ______________ Phone Number (________) ______________

PART 3 - PHYSICIAN INFORMATION

Physician ______________ (First Name) ____ (Initial) ______________ (Last Name) Specialty ______________

Address ______________ (Street) ______________ (City) ______ (Province) ______ (Postal Code)

Telephone (________) ______________ Fax (________) ______________

Name of Requested Drug ______________ DIN ______________ Strength ______________

Expected Duration of Therapy ______________ Anticipated Monthly Cost $ ______________

Diagnosis and Stage of Disease ______________

1. Has the patient been diagnosed with non-valvular atrial fibrillation? ☐ Yes ☐ No
2. Does the patient have a CHADS2 score ≥ than 1? ☐ Yes ☐ No

PART 3 - PHYSICIAN INFORMATION (CONTINUED)

3. Is the patient's anticoagulation inadequate following a reasonable trial on warfarin? ☐ Yes ☐ No
4. Does the patient have limited access to International Normalized Ratio (INR) testing services at a laboratory, clinic, pharmacy or at home? ☐ Yes ☐ No

Prescription Renewal ☐ Yes ☐ No

If Yes, please provide objective evidence of efficacy ____________________

I hereby certify that the information provided in this request is true, complete and accurate.

Physician Signature ____________________ Date ____________________
MMM/DD/YYYY

PART 4 - PATIENT/GUARDIAN AUTHORIZATION

Co-operators Life Insurance Company Privacy Statement
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I authorize Co-operators Life Insurance Company (a) to use the personal information disclosed on this form, and any other personal information known to Co-operators Life Insurance Company regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional or health care management consultant, having knowledge of such patient's health relevant to this request and any related claim.

I hereby certify that the information provided in this request is true, complete and accurate.

Patient/Legal Guardian Name ____________________ Telephone (__________)____________________

Signature of Patient/Legal Guardian ____________________ Date ____________________
MMM/DD/YYYY