

# GROUP BENEFITS PRIOR AUTHORIZATION FORM VALCYTE (valganciclovir)

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 \_\_\_\_\_ Relationship to Plan Member  
MMM/DD/YYYY

## 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 \_\_\_\_\_

\*It is recommended that, when appropriate, patient starts on generic valganciclovir

Expected Duration of Therapy \_\_\_\_\_ Anticipated Monthly Cost \$ \_\_\_\_\_

Diagnosis and Stage of Disease \_\_\_\_\_

**PART 3 - PHYSICIAN INFORMATION (CONTINUED)**

1. Has the patient been diagnosed with AIDS and CMV retinitis, and requesting valganciclovir for the treatment of cytomegalovirus (CMV) retinitis? .....  Yes  No

2. Is the patient a solid organ transplant patient, and requesting valganciclovir for the prevention of CMV retinitis? .....  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