the co-operators®
A Better Place For You®

GROUP BENEFITS PRIOR AUTHORIZATION FORM PROLASTIN-C

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 _____

Please indicate phenotype of alpha1-antitrypsin deficiency _____

Is the patient currently a non-smoker? ☐ Yes ☐ No

PART 3 - PHYSICIAN INFORMATION (CONTINUED)

What is the patient's serum level of alpha1-antitrypsin? _____

What is the patient's baseline percent predicted FEV1? _____

Does the patient have clinically demonstrable panacinar emphysema? _____

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