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A Better Place For You®

GROUP BENEFITS PRIOR AUTHORIZATION FORM MULTIPLE SCLEROSIS

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 (TO BE COMPLETED BY PATIENT)

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 (TO BE COMPLETED BY PATIENT)

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.

Are you currently on, or have previously been on this medication? ☐ Yes ☐ No

If yes, start date _____ (MMM/DD/YYYY) Coverage provided by _____

Are you currently receiving disability benefits (short-term or long-term) for the condition for which this medication has been prescribed? ☐ Yes ☐ No

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 Contact Name _____ Telephone (_____) _____

PART 3 - PATIENT/GUARDIAN AUTHORIZATION (TO BE COMPLETED BY PATIENT)

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)

PART 4 - MEDICAL INFORMATION (TO BE COMPLETED BY PHYSICIAN)

PRESCRIBER INFORMATION

Physician _____ _____ _____ Specialty _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone (_____) _____ Fax (_____) _____ Registration Number _____

MEDICATION REQUESTED (maximum approval for one-year)

Alemtuzumab: ☐ Lemtrada 12mg/1.2mL vial

Cladribine: ☐ Mavenclad 10mg tablet

Dimethyl Fumarate: ☐ Tecfidera 120mg capsule
☐ Tecfidera 240mg capsule

Fingolimod: ☐ Gilenya 0.5mg capsule

Glatiramer Acetate: ☐ Copaxone 20mg/mL syringe
☐ Copaxone 40mg/mL syringe
☐ Glatect 20mg/mL syringe

Interferon Beta-1a: ☐ Avonex 30mcg/0.5mL injection
☐ Rebif 66mcg injection
☐ Rebif 132mcg injection
☐ Rebif 22mcg prefilled syringe
☐ Rebif 44mcg prefilled syringe

Interferon Beta-1b: ☐ Betaseron 0.3mg vial
☐ Extavia 0.3mg vial

Natalizumab: ☐ Tysabri 300mg/15mL

Ocrelizumab: ☐ Ocrevus 300mg/10mL vial

Peginterferon Beta-1a: ☐ Plegridy 63-94mcg/0.5 mL prefilled syringe
☐ Plegridy 125mcg/0.5mL
☐ Plegridy 125mcg/0.5 mL prefilled syringe
☐ Plegridy 163mcg/0.5mL

Teriflunomide: ☐ Aubagio 14mg tablet

Other: ☐ _____

Directions for use (i.e. prescription sig) _____

Name of facility where treatment will be administered (e.g. home, physician's office, specialty clinic, hospital) _____

CLINICAL INFORMATION

Diagnosis: ☐ Relapsing-remitting multiple sclerosis ☐ Secondary-progressive multiple sclerosis ☐ Other _____

Patient's Current Expanded Disability Score (EDSS) _____ Date _____
MMM/DD/YYYY

Previous EDSS score (if available) _____ Date _____
MMM/DD/YYYY

Date of initial diagnosis _____ Patient's current weight _____
MM/YYYY

Qualifying relapses/attacks: Please provide dates of most recent relapses/attacks (an attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 24 hours in the absence of fever, and preceded by stability for at least one month):

Date (MMM/DD/YYYY)	**Type of Relapse (One MRI relapse may substitute for one clinical relapse)**
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s)) ☐ Other _____
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s)) ☐ Other _____
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s)) ☐ Other _____
	☐ Clinical relapse ☐ MRI relapse (T1 gadolinium-enhancing lesion(s)) ☐ Other _____

If this is NOT the patient's first MS disease modifying therapy (DMT):

Has the patient been on MS DMT since the relapse(s)? ☐ Yes ☐ No

Has there been any interruptions in therapy since starting MS DMT? ☐ Yes ☐ No

If yes, indicate:

Reason for interruption of therapy _____

Time period of interruption: From _____ To _____
MMM/DD/YYYY MMM/DD/YYYY

How many relapses did the patient experience while off therapy? _____

PART 4 - MEDICAL INFORMATION (CONTINUED)

RELEVANT CURRENT/PREVIOUS THERAPIES

Medication Name	Dosing Regimen	Start Date (MM/YYYY)	End Date (MM/YYYY)	Patient Response

ADDITIONAL INFORMATION

Please provide/attach all relevant clinical information to support medical necessity of medication therapy requested including any relevant lab tests which may support choice of medication therapy:

RENEWAL COVERAGE CRITERIA

Date patient started current medication _____ (MM/YYYY) Current patient weight _____

Evidence of continued benefit (improvement or stabilization) as show by at least ONE of the following:

- ☐ Reduction in relapse/attack rate (decrease from _____ relapses/attacks per year to _____ relapses/attacks per year)
- ☐ Improvement or stability of EDSS score
  - Most recent EDSS score _____ Date _____ (MMM/DD/YYYY)
  - Previous EDSS score _____ Date _____ (MMM/DD/YYYY)
- ☐ MRI scan: reduction or stability in lesion load
- ☐ MRI scan: reduction in gadolinium enhancing lesions
- ☐ Overall clinical impression of benefit (please provide details) _____

Please provide any additional comments regarding patient's current medical status as applicable:

Please be advised further information may be requested if needed to facilitate determination of coverage.

Prescribing Physician's Signature _____ Date _____ (MMM/DD/YYYY)