the co-operators
A Better Place For You®

GROUP BENEFITS
PRIOR AUTHORIZATION FORM
INFLAMMATORY BOWEL DISEASE
(CROHN'S DISEASE/ULCERATIVE COLITIS)

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 ______________________ ______ ______________________ ☐ Male ☐ Female
First Name Initial Last Name

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 ______________________ ______ ______________________ ☐ Male ☐ Female
First Name Initial Last Name

Address ______________________ ______________________ ______ ______
Street City Province Postal Code

Date of Birth ______________________ Relationship to Plan Member ______________________
MMM/DD/YYYY

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 ______________________ Coverage provided by ______________________
MMM/DD/YYYY

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 ______________________ (First Name) ____ (Initial) ______________________ (Last Name) Specialty ______________________

Address ______________________ (Street) ______________________ (City) ________ (Province) ________ (Postal Code)

Telephone (________) ______________________ Fax (________)______________________ Registration Number ______________________

MEDICATION REQUESTED (maximum approval for one-year)

Adalimumab: ☐ Humira 40mg/0.8mL

Golilumab: ☐ Simponi 50mg/0.5mL syringe
☐ Simponi 50mg/0.5mL autoinjector
☐ Simponi 50mg/0.5mL syringe
☐ Simponi 50mg/0.5mL autoinjector
☐ Simponi IV

Infliximab: ☐ Remicade 100mg vial
☐ Inflectra 100mg vial
☐ Remsima 100mg vial

Ustekinumab: ☐ Stelara 45mg/0.5mL
☐ Stelara 90mg/mL
☐ Stelara IV

Vedolizumab: ☐ Entyvio 300mg vial

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) ______________________

If this medication will be administered in a hospital, what will the patient be treated as? ☐ In-patient ☐ Out-patient

CLINICAL INFORMATION

Diagnosis ______________________ Date of initial diagnosis ____________ (MM/YYYY)

Anticipated duration for treatment (max. approval is one year before renewal required) ____________ Patient's current weight ____________

Does patient have any relevant drug allergies? ☐ Yes ☐ No

If yes, Nature of Allergy ______________________

Has the patient been hospitalized for this condition? ☐ Yes ☐ No

If yes, Date of Admission ____________ (MMM/DD/YYYY) Date of Discharge ____________ (MMM/DD/YYYY)

Will the patient be maintained on methotrexate (MTX) in combination with the requested medication? ☐ Yes ☐ No

If not, please specify reason ______________________

ESR ________ Date ____________ (MMM/DD/YYYY) CRP ________ Date ____________ (MMM/DD/YYYY)

For Crohn's Disease:

Current Harvey-Bradshaw Index ______ Date ____________ (MMM/DD/YYYY) or Crohn's Disease Activity Index ______ Date ____________ (MMM/DD/YYYY)

Presence of extraintestinal manifestations: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Please specify ______________________

For Moderate to Severe Crohn's Disease:

Indicate site: ☐ Isolated colonic ☐ Ileal colonic ☐ Small bowel ☐ Other ______________________

For Fistulizing Crohn's Disease:

Number of Fistulae ______ Site of fistula(e): ☐ Perianal ☐ Enterocutaneous ☐ Recto-Vaginal ☐ Other ______________________

Surgical intervention: ☐ Attempted ☐ Contemplated ☐ Not indicated

Fistula drainage and bleeding: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Pain at fistula sites: ☐ None ☐ Mild ☐ Moderate ☐ Severe

For Ulcerative Colitis:

Current MAYO score ______ Date ____________ (MMM/DD/YYYY) Endoscopic subscore ______ Date Performed ____________ (MMM/DD/YYYY)

CO-OPERATORS LIFE INSURANCE COMPANY
1920 COLLEGE AVENUE REGINA SK S4P 1C4

PART 4 - MEDICAL INFORMATION (CONTINUED)

RELEVANT CURRENT/PREVIOUS THERAPIES

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

If a switch to a different biological agent is requested, please provide reason ____________________

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 ________

For Moderate To Severe Crohn's Disease:

If patient flaring before next dose, Duration of Response ____________________ Current Harvey-Bradshaw Index ________

For Fistulizing Crohn's Disease:

If patient flaring before next dose, Duration of Response ____________________ Number of fistulae ______

Fistula response to treatment: ☐ Worse ☐ None ☐ Moderate ☐ Resolved

Fistula drainage and bleeding: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Pain at fistula sites: ☐ None ☐ Mild ☐ Moderate ☐ Severe

For Ulcerative Colitis:

Current MAYO score ________ Date ____________ (MMM/DD/YYYY)

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)