the co-operators®
A Better Place For You®

GROUP BENEFITS PRIOR AUTHORIZATION FORM SEVERE PSORIASIS

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)

Adalimumab: ☐ Humira 40mg/0.8mL

Apremilast: ☐ Otezla 30mg

Brodalumab: ☐ Siliq 210mg/1.5mL

Etanercept: ☐ Enbrel 25mg/kit ☐ Enbrel 50mg/mL

Guselkumab: ☐ Tremfya 100mg/mL

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

Ixekizumab: ☐ Taltz 80mg/1.0mL

Secukinumab: ☐ Cosentyx 150mg/1.0mL

Ustekinumab: ☐ Stelara 45mg/0.5mL ☐ Stelara 90mg/1.0mL

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: _____

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

Anticipated duration for treatment (max. approval is one year before renewal required) _____

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

If yes, what is the nature of the allergy: _____

Current Psoriasis Area Severity Index (PASI) _____ Date _____ (MMM/DD/YYYY)

Dermatology Life Quality Index (DLQI) _____ Date _____ (MMM/DD/YYYY)

% body surface area (BSA) _____ Areas of body involved _____

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

If no, please specify reason: _____

RELEVANT CURRENT/PREVIOUS THERAPIES (including ALL immunosuppressants, prior biologics, steroids, and topical therapies)

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

UV phototherapy: ☐ Failed to respond ☐ Intolerant ☐ Unable to access ☐ Did not attempt

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

PART 4 - MEDICAL INFORMATION (CONTINUED)

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 _____

Pre-biologic PASI score _____ Date _____ (MMM/DD/YYYY)

Current PASI 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)