the co-operators
A Better Place For You®

GROUP BENEFITS PRIOR AUTHORIZATION FORM SEVERE ASTHMA

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 ____________________ (First Name) ______ (Initial) ____________________ (Last Name) Specialty ____________________

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

Telephone (________) ____________________ Fax (_________)____________________ Registration Number ____________________

MEDICATION REQUESTED

Benralizumab: ☐ Fasenra 30 mg/mL syringe Omalizumab: ☐ Xolair 150 mg vial Other: ____________________

Mepolizumab: ☐ Nucala 100 mg vial Reslizumab: ☐ Cinqair 100 mg vial

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

Where will treatment be administered (e.g. in hospital, in physician's office, at home)?

a. Name of facility ____________________
b. If this medication will be administered in a hospital, will the patient be treated as an ☐ in-patient or ☐ out-patient?

CLINICAL INFORMATION

Diagnosis ____________________ Date of Initial Diagnosis ____________________ (MM/YYYY)

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

Current patient weight ______________ Does patient have any relevant drug allergies? ☐ Yes ☐ No

Nature of allergy, if applicable ____________________

Pre-biologic Asthma Control Questionnaire (ACQ) Score____________________ Date ____________________ (MMM/DD/YYYY)

Pre-biologic Asthma Control Test (ACT) Score ____________________ Date ____________________ (MMM/DD/YYYY)

Pre-biologic FEV1 (pre-bronchodilator % predicted) ____________________ Date ____________________ (MMM/DD/YYYY)

Has the patient been hospitalized for an asthma exacerbation in the previous 12 months? .... ☐ Yes ☐ No

If yes, please specify the number of exacerbations ____________________

Has the patient required oral corticosteroids or an increase in oral corticosteroid dose due to an asthma exacerbation in the previous 12 months? ..... ☐ Yes ☐ No

If yes, please specify the number of exacerbations ____________________

FOR ALLERGIC ASTHMA

Pre-biologic serum immunoglobulin (IgE) ____________________ Date ____________________ (MMM/DD/YYYY)

Allergic sensitization to a perennial allergen? .... ☐ Yes ☐ No

If yes, please specify allergen(s) ____________________

Please provide documentation of positive skin testing or in vitro testing for allergen-specific IgE.

FOR EOSINOPHILIC ASTHMA

Pre-biologic absolute eosinophil count ____________________ Date ____________________ (MMM/DD/YYYY)

RELEVANT CURRENT/PREVIOUS THERAPIES

(including ALL prior biologics, corticosteroids, and bronchodilators)

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

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

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 ______________

Current Asthma Control Questionnaire (ACQ) Score ________________________________ Date ______________ (MMM/DD/YYYY)

Current Asthma Control Test (ACT) Score ________________________________ Date ______________ (MMM/DD/YYYY)

Current FEV1 (pre-bronchodilator % predicted) ________________________________ Date ______________ (MMM/DD/YYYY)

Has the patient been hospitalized for an asthma exacerbation in the previous 12 months? ☐ Yes ☐ No

If yes, please specify the number of exacerbations ________________________________

Has the patient required oral corticosteroids or an increase in oral corticosteroid dose due to an asthma exacerbation in the previous 12 months? ☐ Yes ☐ No

If yes, please specify the number of exacerbations ________________________________

Please provide/attach any additional clinical information to support the renewal of the requested medication:

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