the co-operators®
A Better Place For You®

GROUP BENEFITS PRIOR AUTHORIZATION FORM PSORIATIC ARTHRITIS

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 (maximum approval for one-year)

Adalimumab:	☐ Humira 40mg/0.8mL syringe ☐ Humira 40mg/0.8mL pen ☐ Humira 40mg/0.8mL vial	Golimumab:	☐ Simponi 50mg/0.5mL syringe ☐ Simponi 50mg/0.5mL autoinjector ☐ Simponi 100mg/1mL syringe ☐ Simponi 100mg/1mL autoinjector ☐ Simponi IV/4mL vial	Secukinumab:	☐ Cosentyx 150mg/mL syringe ☐ Cosentyx 150mg/mL pen
Apremilast:	☐ Otezla 10mg tablet ☐ Otezla 20mg tablet ☐ Otezla 30mg tablet	Infliximab:	☐ Remicade 100mg vial ☐ Inflectra 100mg vial ☐ Remsima 100mg vial	Ustekinumab:	☐ Stelara IV 130mg/26mL vial ☐ Stelara SC 45mg/0.5mL syringe ☐ Stelara SC 90mg/mL syringe ☐ Stelara SC 45mg/0.5mL vial ☐ Stelara SC 90mg/mL vial
Certolizumab Pegol:	☐ Cimzia 200mg/mL syringe				
Etanercept:	☐ Enbrel 25mg/kit ☐ Enbrel 50mg/mL			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 _____ (MMM/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 _____

DAS28 Score _____ Date _____ (MMM/DD/YYYY)

HAQ Score _____ Date _____ (MMM/DD/YYYY)

68 Joint Count: Number of Swollen Joints _____ Number of Tender Joints _____

Please provide radiographic evidence of psoriatic arthritis

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 (MMM/YYYY)	End Date (MMM/YYYY)	Patient Response

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 _____ (MMM/YYYY) Current patient weight _____

DAS28 Score _____ Date _____ (MMM/DD/YYYY)

HAQ Score _____ Date _____ (MMM/DD/YYYY)

68 Joint Count: Number of Swollen Joints _____ Number of Tender Joints _____

	Medication	Dose	Route	Frequency
Concurrent DMARD therapy OR ☐ Mark here if none				

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

I certify that the information provided is true, correct, and complete.
Please be advised further information may be requested if needed to facilitate determination of coverage.

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