the co-operators
A Better Place For You®

GROUP BENEFITS PRIOR AUTHORIZATION FORM ANKYLOSING SPONDYLITIS

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

Certolizumab Pegol: ☐ Cimzia 200mg/mL

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

Golilumab: ☐ Simponi 50mg/0.5mL syringe
☐ Simponi 50mg/0.5mL autoinjector
☐ Simponi 100mg/1mL syringe
☐ Simponi 100mg/1mL autoinjector
☐ Simponi IV

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

Secukinumab: ☐ Cosentyx 150mg

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

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 ____

BASDAI Score __________ Date ____________
MMM/DD/YYYY

10cm VAS Spine Score on 2 occasions at least 12 weeks apart: Score __________ Date ____________
MMM/DD/YYYY

Score __________ Date ____________
MMM/DD/YYYY

Please attach radiographic evidence demonstrating severe active disease

RELEVANT CURRENT/PREVIOUS THERAPIES (including ALL NSAIDS, analgesics, DMARDS, and prior biologics)

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:

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PART 4 - MEDICAL INFORMATION (CONTINUED)

RENEWAL COVERAGE CRITERIA

Date patient started current medication ______________________ Current patient weight ____________
MM/YYYY

Pre-treatment BASDAI Score __________________ Date _______________________
MMM/DD/YYYY

Current BASDAI _______________ Date _______________________
MMM/DD/YYYY

	Medication	Dose	Route	Frequency
Concurrent analgesic 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

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