

# GROUP BENEFITS PRIOR AUTHORIZATION FORM RHEUMATOID 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 \_\_\_\_\_ 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 \_\_\_\_\_ Specialty \_\_\_\_\_  
First Name Initial Last Name  
Address \_\_\_\_\_  
Street City Province Postal Code  
Telephone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ Registration Number \_\_\_\_\_

**MEDICATION REQUESTED** (maximum approval for one-year)

- |  |  |  |
|--|--|--|
| Adalimumab: <input type="checkbox"/> Humira 40mg/0.8mL       | Golimumab: <input type="checkbox"/> Simponi 50mg/0.5mL syringe | Sarilumab: <input type="checkbox"/> Kevzara 150mg              |
| Abatacept: <input type="checkbox"/> Orencia 250mg vial       | <input type="checkbox"/> Simponi 50mg/0.5mL autoinjector       | <input type="checkbox"/> Kevzara 200mg                         |
| <input type="checkbox"/> Orencia 125mg syringe               | <input type="checkbox"/> Simponi 100mg/1mL syringe             | Tocilizumab: <input type="checkbox"/> Actemra IV 80mg/4mL vial |
| Anakinra: <input type="checkbox"/> Kineret 100mg syringe     | <input type="checkbox"/> Simponi 100mg/1mL autoinjector        | <input type="checkbox"/> Actemra IV 200mg/10mL vial            |
| Certolizumab Pegol: <input type="checkbox"/> Cimzia 200mg/mL | <input type="checkbox"/> Simponi IV                            | <input type="checkbox"/> Actemra IV 400mg/20mL vial            |
| Etanercept: <input type="checkbox"/> Brenzys 50mg/mL         | Infliximab: <input type="checkbox"/> Remicade 100mg vial       | <input type="checkbox"/> Actemra 162mg syringe                 |
| <input type="checkbox"/> Enbrel 25mg/kit                     | <input type="checkbox"/> Inflectra 100mg vial                  | Tofacitinib: <input type="checkbox"/> Xeljanz 5mg              |
| <input type="checkbox"/> Enbrel 50mg/mL                      | Rituximab: <input type="checkbox"/> Rituxan 10mg/mL            | Other: _____   |
|  | <input type="checkbox"/> Rituxan SC 120mg/mL                   |  |

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 \_\_\_\_\_

DAS28 Score \_\_\_\_\_ or PAS/PAS-II Score \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY

HAQ Score \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY

68 Joint Count: Number of Swollen Joints \_\_\_\_\_ Number of Tender Joints \_\_\_\_\_

- Presence of any of the following features:  Extraarticular disease (e.g., presence of rheumatoid nodules, RA vasculitis, Felty's syndrome)
- Positive rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP) antibodies
- Body erosions by radiograph

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 <small>(MM/YYYY)</small>	End Date <small>(MM/YYYY)</small>	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 \_\_\_\_\_ Current patient weight \_\_\_\_\_  
MM/YYYY

DAS28 Score \_\_\_\_\_ or PAS/PAS-II Score \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY

HAQ Score \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY

68 Joint Count: Number of Swollen Joints \_\_\_\_\_ Number of Tender Joints \_\_\_\_\_

- Presence of any of the following features:  Extraarticular disease (e.g., presence of rheumatoid nodules, RA vasculitis, Felty's syndrome)  
 Positive rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP) antibodies  
 Body erosions by radiograph

	<b>Medication</b>	<b>Dose</b>	<b>Route</b>	<b>Frequency</b>
Concurrent DMARD therapy				
OR				
<input type="checkbox"/> 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