

GROUP BENEFITS PRIOR AUTHORIZATION FORM CHRONIC HEPATITIS C

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)

Medication Name _____
Directions for use (i.e. prescription sig) _____

CLINICAL INFORMATION

Hepatitis C Genotype _____ Date of Initial Diagnosis _____ Current Patient Weight _____
MM/YYYY

1. Treatment naïve? Yes No
2. Has patient had detectable Hepatitis C RNA within last six months? Yes No
3. Patient's most recent METAVIR fibrosis score by liver biopsy: _____
4. Is patient a liver transplant recipient? Yes No
 If yes, where and when: _____
5. Does patient have Type 2 or 3 essential cryoglobulinemia present with end-organ manifestations? Yes No
 If yes, describe: _____
6. Is glomerular disease present? Yes No
 If yes, describe: _____
7. Does patient have compensated liver disease (Child Pugh ≤ 6)? Yes No
8. Does patient have extrahepatic manifestations of Hepatitis C infection? Yes No
 If yes, describe and provide documentation: _____

Please attach the most recent Hepatitis C Virus Nucleic Acid (RNA) Test and evidence of Fibrosis Score

RELEVANT CURRENT/PREVIOUS THERAPIES

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

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:

Please be advised further information may be requested if needed to facilitate determination of coverage.

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