Drug Prior Authorization Form
Adalimumab

The purpose of this form is to obtain information required to assess your drug claim.

IMPORTANT: Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

Any costs incurred for the completion of this form are the responsibility of the plan member/patient.

Privacy

Protecting your personal information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your **online account** or by submitting a request through our **privacy centre** at **canadalife.com/privacy**. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit **canadalife.com/privacy.**

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Privacy consent, authorization, and declaration

I understand that my personal information will be collected, used and shared as set out above.

Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given below is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

I agree that by submitting this form or authorizing it to be submitted, I am consenting to the terms set out in this section, even if I have not signed the form.

Plan Member's signature: _____ Date: _____

Form completion instructions

1. **Complete "Patient Information" sections.**
2. **Please review and sign the form.**
3. **Have the prescribing *physician complete the "Physician Information" sections.** ***(In Quebec, by law this information is not required to be provided by a physician. Other treating healthcare providers can also complete this form in Quebec).***
4. **Send all pages of the completed form to us by mail, fax or email as noted below.**

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to:
The Canada Life Assurance Company
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to:
The Canada Life Assurance Company
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to:
cldrug.services@canadalife.com
Attention: Drug Claims Management

For additional information regarding Prior Authorization and Health Case Management, please visit our Canada Life website at **canadalife.com** or contact Group Customer Contact Services at 1-800-957-9777. Deaf or hard of hearing and require access to a telecommunications relay service? Please contact us: TTY to Voice: 711 or Voice to TTY: 1-800-855-0511.

canada life™

Patient Information
Adalimumab

Plan member information – Complete all sections of this page (please print)

Plan Member: _____ Patient Name: _____

Plan Name: _____ Plan Number: _____ Plan Member ID Number: _____

Patient Date of Birth (dd/mm/yyyy): _____ Address (number, street, city, province, postal code): _____

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient:

_____

May we contact you by email? (Note that some correspondence may still need to be sent by regular mail). ☐ Yes ☐ No

If yes, please provide email address:

_____

Treatment history with this drug

Is the patient currently on, or previously been on this drug? ☐ Yes ☐ No

If Yes, a) indicate start date (dd/mm/yyyy): _____

b) coverage provided by: _____

(if coverage is not provided by Canada Life please provide pharmacy print-out showing purchase of this drug)

Other benefit plans

Does the patient have drug coverage under any other group benefits plan? ☐ Yes ☐ No

If Yes, name of other Insurance Company: _____

If other plan is with Canada Life, tell us the plan and ID number: _____

Name of plan member: _____

Relationship to patient: _____

Provide details and attach documentation of acceptance or decline:

_____

Provincial programs or other coverage

Does the patient have coverage under a provincial program or from any other source? ☐ Yes ☐ No

If Yes, name of program or other source: _____

Provide details and attach documentation of acceptance or decline: _____

Is the patient currently receiving disability benefits for the condition for which this drug has been prescribed? ☐ Yes ☐ No

Patient support program details

Has the patient enrolled in the patient support program for this drug? ☐ Yes ☐ No

If yes, please provide the following information:

1. Patient support program patient ID Number: _____
2. Patient assistance program contact person name and phone number:

Contact Name: _____ Phone Number: _____

Physician Information
Adalimumab

Note to *Physician: In order to assess a patient's claim for this drug, we require detailed information on the patient's prescription drug history as requested below. *(In Quebec, by law this information is not required to be provided by a physician. Other treating healthcare providers can also complete this form in Quebec).*

Attach extra information if necessary. GENETIC TEST RESULTS ARE NOT REQUIRED.

Physician's information (please print)

Name of prescribing physician:

Specialty:

Address (number, street, city, province, postal code):

Telephone Number (including area code):

Fax Number (including area code):

1. Prescribed dosage and regimen:

Prescribed Drug	Loading dose	Maintenance dose	Regimen
☐ **Abrilada** ☐ **Amgevita** ☐ **Hadlima** ☐ **Hulio** ☐ **Humira** ☐ **Hyrimoz** ☐ **Idacio** ☐ **Simlandi** ☐ **Yuflyma**	☐ 80mg at week 0 ☐ 160mg at week 0, 80mg at week 2	☐ 20mg ☐ 40mg	☐ Weekly ☐ Every other week ☐ Other (please specify): _____ Provide rationale: _____ Patient's weight: _____ kg Date determined (dd/mm/yyyy): _____

2. Health Canada Indication (include date of initial diagnosis)(mm/yyyy): _____

☐ Ankylosing Spondylitis
☐ Crohn's Disease
☐ Hidradenitis Suppurativa
☐ Plaque Psoriasis
☐ Polyarticular Juvenile Idiopathic Arthritis
☐ Psoriatic Arthritis
☐ Rheumatoid Arthritis
☐ Ulcerative Colitis - Adult
☐ Ulcerative Colitis - Pediatrics
☐ Uveitis - Adults
☐ Uveitis - Pediatric

Complete questions 1 - 6 and Physician's information

☐ Other (approved by Health Canada): _____

Complete questions 1 – 6 and Other condition (Health Canada approved)

☐ Other (prescribed use is not approved by Health Canada): _____

Complete questions 1 – 6 and Off-label use

3. What is the anticipated duration of treatment with this drug? _____

4. Where will treatment be administered? ☐ Home ☐ Physician's Office ☐ Private Clinic ☐ Hospital In-patient ☐ Hospital out-patient

5. Please provide medical rationale why this drug has been prescribed instead of an alternate drug in the same therapeutic class:

Physician's Information (continued) (please print)

6. Drug and Treatment History – **must be completed for every request.** If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

Drug(s) and Treatment(s) past and present	Dosing Regimen	Start Date (dd/mm/yyyy)	End Date (dd/mm/yyyy)	Clinical Results/Outcome
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

Ankylosing Spondylitis

Current result and date of the following scores (dd/mm/yyyy): _____ ASDAS: _____ BASDAI: _____

Has the patient tried and failed 2 NSAIDs for a minimum of 4 weeks each? ☐ Yes ☐ No

If no, please provide medical rationale as to why these medications have not been tried:

Ensure the Drug and Treatment History chart is completed.

Crohn's Disease

Does the patient have a diagnosis of moderate or severe Crohn's Disease? ☐ Yes ☐ No

Please provide the patient's most recent Harvey-Bradshaw Index (HBI): _____

Date determined (dd/mm/yyyy): _____

Does the patient have a diagnosis of fistulizing Crohn's Disease? ☐ Yes ☐ No

Site of disease and complications: _____

Has the patient had a trial of at least one of the following drugs for a minimum of 12 weeks? ☐ Yes ☐ No

Select the drugs:

☐ 6-mercaptopurine ☐ azathioprine ☐ methotrexate IM or SC ☐ prednisone ☐ other: _____

If no, please provide medical rationale as to why these medications have not been tried:

Please ensure Drug and Treatment History chart is completeds (include daily steroid use).

Was adalimumab started in hospital? ☐ Yes ☐ No

Did patient receive a trial of IV steroids for a minimum of 7 days while hospitalized? ☐ Yes ☐ No

Please ensure Drug and Treatment History chart is completed (include daily steroid dose).

Hidradenitis Suppurativa - Initial request

Initial request

Select all that apply:

☐ Diagnosis of moderate to severe hidradenitis suppurativa

☐ Lesions are at Hurley stage II or III

☐ Has had inadequate response to ≥ 3 months of an oral antibiotics

Please provide current total abscess and inflammatory nodule (AN) count: _____ Date (dd/mm/yyyy): _____

Ensure the Drug and Treatment History chart is completed.

Renewal request

Please provide current total abscess and inflammatory nodule (AN) count: _____ Date (dd/mm/yyyy): _____

Has there been an increase to AN count since starting therapy with adalimumab? ☐ Yes ☐ No

Plaque Psoriasis

% BSA: _____

Areas of body involved: _____

Current result and date of the following scores (dd/mm/yyyy): _____ DLQI: _____ PASI: _____

Patient has had an adequate trial of one of the following for a minimum of 12 weeks? ☐ Yes ☐ No

Select the drugs:

☐ acitretin ☐ cyclosporine ☐ methotrexate PO ☐ methotrexate IM or SC* ☐ other: _____

* Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate (IM or SC) to be considered an adequate trial.

If no, please provide medical rationale as to why these medications have not been tried:

_____

Ensure the Drug and Treatment History chart is completed.

Polyarticular Juvenile Idiopathic Arthritis

Select all that apply:

☐ Disease is moderately to severely active

☐ Adalimumab will be used in combination with methotrexate

☐ Patient has documented contraindication or intolerance to methotrexate

Please provide details of contraindiction/intolerance: _____

☐ Patient has tried and failed at least a 12-week trial of one DMARD

Ensure the Drug and Treatment History chart is completed.

Psoriatic Arthritis

Swollen and tender joint count: _____

Current result and date of the following scores (dd/mm/yyyy): _____ HAQ: _____ BASDAI: _____

Has the patient had a trial of two of the following DMARDs for 12 weeks each? ☐ Yes ☐ No

Select the drugs:

☐ azathioprine ☐ leflunomide ☐ methotrexate PO ☐ methotrexate IM or SC* ☐ sulfasalazine ☐ other: _____

* Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate (IM or SC) to be considered an adequate trial.

If no, please provide medical rationale as to why these medications have not been tried:

Ensure the Drug and Treatment History chart is completed.

Rheumatoid Arthritis

Swollen and tender joint count: _____

Current result and date of the following scores (dd/mm/yyyy): _____ DAS28: _____ HAQ: _____

Patient has had a:

☐ minimum 12-week trial of methotrexate plus one other DMARD; OR

☐ trial of 3 consecutive DMARDS

Select one:

☐ azathioprine ☐ leflunomide ☐ methotrexate PO ☐ methotrexate IM or SC* ☐ other: _____

* Patients who experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate (IM or SC) to be considered an adequate trial.

If no, please provide medical rationale as to why these medications have not been tried:

Ensure the Drug and Treatment History chart is completed.

Ulcerative Colitis

Diagnosis of moderate or severe ulcerative colitis? ☐ Yes ☐ No

Was adalimumab started in hospital? ☐ Yes ☐ No

Results and dates of the following Mayo score components:

Mayo rectal bleeding score (0 to 3 points): _____ Date (dd/mm/yyyy): _____

Mayo bowel frequency score (0 to 3 points): _____ Date (dd/mm/yyyy): _____

Mayo clinician's global assessment score (0 to 3 points): _____ Date (dd/mm/yyyy): _____

Pediatric UC activity index (PUCAI) score:

PUCAI (0 to 85 points): _____ Date (dd/mm/yyyy): _____

The patient had a trial of at least one of the following (select all that apply):

☐ Azathioprine for 3 months

☐ 6-mercaptopurine for 3 months

☐ Budesonide 9mg orally for 3 months

☐ Prednisone ≥40mg orally for 7 days

☐ IV steroids for: ☐ 3 days ☐ 5 days ☐ 7 days

☐ Other (please specify): _____

Will adalimumab be used concurrently with other UC therapies? ☐ Yes ☐ No

If yes, please specify: _____

Ensure the Drug and Treatment History chart is completed for previous and concurrent UC therapies (include daily steroid use).

Uveitis – Adults

Select all that apply:

☐ Patient has active disease and has had an inadequate response to at least 2 weeks of high dose oral corticosteroids

☐ Patient is dependent on oral corticosteroids, which have been used for at least 4 weeks, to maintain inactive disease

☐ Patient is contraindicated to corticosteroids. Provide detail:

_____

☐ Patient has failed or has contraindications to at least one other immunosuppressive agent

Ensure the Drug and Treatment History chart is completed.

Uveitis – Pediatric

Select all that apply:

☐ Diagnosis of chronic non-infectious anterior uveitis associated with juvenile idiopathic arthritis

☐ Adalimumab will be used in combination with methotrexate

☐ Patient has failed at least a 12-week trial or has contraindications to conventional therapy

If contraindications, please explain:

Ensure the Drug and Treatment History chart is completed.

Other condition (Health Canada approved) – Genetic test results are not required

Provide any relevant information related to the disease and attach supporting documentation.

_____

Physician Information
Adalimumab

Renewal Request

Start date of treatment (mm/yyyy): _____

Describe the patient's response to treatment, particularly in relation to the signs and symptoms of their disease at initial presentation. Attach copies of relevant test results, specialist's consultation or clinical notes

Off-label use – Genetic test results are not required

Questions 1 – 6 must be completed.

Date of initial diagnosis (dd/mm/yyyy): _____

Is there clinical evidence supporting the off-label use of this drug? ☐ Yes ☐ No

Provide clinical literature/studies to support the request for off-label use, such as:

- At least two Phase II or two Phase III clinical trials showing consistent results of efficacy; and
- Published recommendations in evidence-based guidelines supporting its use.

Provide medical rationale why this drug has been prescribed off-label instead of an alternate drug with an approved indication for this condition.

Provide any pertinent medical history or information to support this off-label request.

If this is a renewal request, provide documentation showing treatment efficacy since previous request.

Note for Physician: To be eligible for reimbursement, Canada Life may require your patient to purchase a drug requiring prior authorization from a pharmacy designated by Canada Life. If applicable, a health case manager will contact you with further information.

I certify that the information provided is true, correct, and complete.

Physician's Signature: _____ Date (dd/mm/yyyy): _____

License Number: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit. The completed form can be returned to Canada Life by mail, fax, or email.

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

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