Drug Prior Authorization Form
Dupixent (dupilumab)

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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Drug Prior Authorization Form
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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.

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Patient Information
Dupixent (dupilumab)

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: _____

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Physician Information
Dupixent (dupilumab)

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:

INDUCTION	MAINTENANCE
☐ 400mg at Week 0	☐ 200mg every other week
☐ 600mg at Week 0	☐ 300mg every other week
	☐ 300mg once weekly

☐ Other (please specify): _____

Provide rationale : _____

Patient's weight: _____ kg

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

☐ Severe asthma
☐ Atopic dermatitis
☐ Chronic rhinosinusitis with nasal polyps
☐ Chronic Obstructive Pulmonary Disease
☐ Chronic Urticaria
☐ Eosinophilic esophagitis
☐ Prurigo Nodularis

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:

Severe Asthma

Does the patient have a diagnosis of severe Type 2/eosinophilic asthma, as demonstrated by a current, eosinophil count of ≥150cells/uL or FeNO ≥ 20ppb?

☐ Yes ☐ No

Copies of laboratory report must be provided.

Has the patient had oral corticosteroid dependent asthma (defined as 5 to 35mg prednisone or equivalent daily) for ≥ 6 months? ☐ Yes ☐ No

Ensure the Drug and Treatment History chart is completed.

Has the patient had an inadequate response to ≥ 3 months treatment with medium to high inhaled corticosteroid (ICS) + 2nd/3rd line controller (ie: Long acting B2 agonist (LABA), leukotriene receptor antagonist, combination ISC/LABA)? ☐ Yes ☐ No

Ensure the Drug and Treatment History chart is completed.

If the patient is 6-11 years old, has the patient had inadequate response to ≥ 3 months treatment of high-dose inhaled corticosteroid (ICS) alone? ☐ Yes ☐ No

Please ensure Drug and Treatment History Chart is completed.

Dupixent will be used as add on Maintenance asthma therapy to:

☐ For patients 6-11 years of age, high-dose inhaled corticosteroids alone

☐ One medium- high dose ICS product AND one asthma controller medication (LABA, leukotriene receptor agonist or theophylline)

☐ Other: _____

Will Dupixent be used in combination with another biologic medication (eg: omalizumab, mepolizumab, reslizumab or benralizumab, tezepelumab)?

☐ Yes ☐ No

Please indicate the number of asthma exacerbations for the previous 12 months that required:

Hospitalization _____ Urgent visits to physician or emergency room _____

Dates of admissions: Date of visits:

Physician's Information (continued) (please print)

Severe Asthma (continued)

Renewals:

Date Dupixent was started (mm/yyyy): _____

Has the patient demonstrated a positive clinical response to treatment?

☐ Yes ☐ No

Please provide details:

☐ Decrease or elimination of oral corticosteroid requirements

Dose at initiation: _____

Current dose: _____

☐ Decrease in clinically significant exacerbations. Please provide details of any exacerbations since initiation of therapy:

_____

☐ Improvement in asthma control questionnaire score from baseline

Result and date (mm/yyyy) prior to therapy: _____

Current result and date (mm/yyyy): _____

Attach copy of completed questionnaires.

☐ Improvement in % predicted FEV_1

FEV1 prior to therapy and date (mm/yyyy): _____

Current FEV_1 and date (mm/yyyy): _____

Attach spirometry results.

☐ Other. Provide details:

_____

Will Dupixent continue to be used as add-on maintenance asthma therapy? ☐ Yes ☐ No

Will Dupixent be used in combination with another biologic medication (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, tezepelumab)?

☐ Yes ☐ No

Atopic dermatitis

Please indicate atopic dermatitis severity: ☐ Mild ☐ Moderate ☐ Severe

Please indicate the percentage affected body surface area (BSA): _____

Please indicate affected area(s): _____

Has UV therapy been trialed for this patient? ☐ Yes ☐ No

If yes, please indicate start and stop dates (dd/mm/yyyy) along with reason(s) for discontinuation:

_____

Will Dupixent be used in combination with another JAK inhibitor or biologic treatment for atopic dermatitis? ☐ Yes ☐ No

Please submit at least one of the following at baseline and for renewal:

EASI Score prior to starting Dupixent: _____ Date determined (mm/yyyy) _____

Current EASI score at Dupixent renewal: _____ Date determined (mm/yyyy) _____

IGA score prior to starting Dupixent: _____ Date determined (mm/yyyy) _____

Current IGA score at Dupixent renewal: _____ Date determined (mm/yyyy) _____

Ensure the Drug and Treatment History chart is completed.

Physician's Information (continued) (please print)

Chronic rhinosinusitis with nasal polyps

The following symptoms have been present for > 12 weeks (select all that apply):

- ☐ mucopurulent discharge
- ☐ nasal obstruction and congestion
- ☐ decreased or absent sense of smell
- ☐ facial pressure or pain

Has the patient had prior sinonasal surgery? ☐ Yes ☐ No

Has the patient had prior systemic corticosteroids for a minimum of 10 consecutive days in the previous 2 years? ☐ Yes ☐ No

Has the patient tried and failed trials of ≥ 12 weeks of intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) OR antileukotriene agents (e.g., montelukast, zafirlukast, zileuton), either separately or together? ☐ Yes ☐ No

Ensure the Drug and Treatment History chart is completed.

Does the patient have presence of bilateral nasal polyps confirmed by endoscopy or computed tomography? ☐ Yes ☐ No

Will Dupixent be used in combination with intranasal corticosteroids? ☐ Yes ☐ No

Will Dupixent be used in combination with another biologic medication (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, tezepelumab)?

☐ Yes ☐ No

Renewals:

Is the patient receiving clinical response from Dupixent? ☐ Yes ☐ No

Please describe:

Will Dupixent be used in combination with intranasal corticosteroids? ☐ Yes ☐ No

Will Dupixent be used in combination with another biologic medication (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, tezepelumab)?

☐ Yes ☐ No

Chronic Obstructive Pulmonary Disease

Initial Request:

Does the patient have symptomatic COPD, defined by an Medical Research Council (MRC) dyspnea scale score of at least 2? ☐ Yes ☐ No

Provide the number of moderate exacerbations this patient has experienced in the last 12 months which required oral corticosteroids or antibiotics: _____

Date of exacerbation(s) (MM/YYYY) _____

Provide the number of severe exacerbations this patient has experienced in the last 12 months which required hospitalization: _____

Date of exacerbation(s) (MM/YYYY) _____

Will Dupixent be used in combination with another biologic medication (eg: Xolair, Nucala, Cinqair, Fasenra, Tezspire)? ☐ Yes ☐ No

Has the patient experienced inadequate response to at least 3 months of treatment with triple therapy for their COPD (including inhaled corticosteroid (ICS), inhaled long-acting beta2 agonist (LABA) and inhaled long-acting muscarinic antagonist (LAMA)? ☐ Yes ☐ No

If the patient is unable to tolerate an inhaled corticosteroid, please provide details of the intolerance or a valid contraindication below:

Will Dupixent be used as an add on to maintenance therapy, consisting of one of the following options (check which applies):

- ☐ Triple ICS/LAMA/LABA therapy
- ☐ In the case of ICS intolerance or contraindication, dual therapy with a LABA and LAMA

Does the patient have a post-bronchodilator FEV1/FVC ratio < 0.7? ☐ Yes ☐ No

Does the patient have a post-broncodilator FEV1 of 30-70% predicted? ☐ Yes ☐ No

Pulmonary function tests must be submitted.

Does the patient have an absolute blood eosinophil count of at least 300 cells per microliter? ☐ Yes ☐ No

Lab report confirming eosinophil count from the last 3 months must be provided.

Ensure the drug and treatment history chart is completed.

Physician's Information (continued) (please print)

Renewal Request:

Date dupilumab was started: _____

Will the patient continue to receive Dupixent as an add-on to maintenance COPD therapy? ☐ Yes ☐ No

Provide the number of moderate exacerbations this patient has experienced in the last 12 months which required oral corticosteroids or antibiotics: _____

Date of exacerbation(s) (MM/YYYY): _____

Provide the number of severe exacerbations this patient has experienced in the last 12 months which required hospitalization: _____

Date of exacerbation(s) (MM/YYYY): _____

Has the patient experienced an improvement in COPD symptoms since starting treatment with Dupixent? ☐ Yes ☐ No

If yes, please provide details:

_____

Has the patient demonstrated an improvement in FEV1 compared to baseline? ☐ Yes ☐ No

Pulmonary function tests from the last 6 months must be submitted.

Has the patient demonstrated an improvement in blood eosinophil count compared to baseline ☐ Yes ☐ No

Eosinophil blood count reports from the last 6 months must be submitted.

Chronic Urticaria

Has the patient been diagnosed with chronic spontaneous/idiopathic urticaria for at least 6 months prior to this application? ☐ Yes ☐ No

Is the patient symptomatic despite regular use of maximum tolerated doses of H1-antihistamine therapy for at least 6 weeks? ☐ Yes ☐ No

Will Dupixent be used in combination with another biologic for the treatment of Chronic Spontaneous/Idiopathic Urticaria? ☐ Yes ☐ No

Ensure the Drug and Treatment History chart is completed.

Eosinophilic esophagitis

Does the patient have active esophageal inflammation with a documented eosinophilia count ≥15 eosinophils per high-power microscopy field (eos/hpf)?

☐ Yes ☐ No

Please provide biopsy report of eosinophilia count.

Dysphagia Symptom Questionnaire (DSQ) score: _____ Date assessed (mm/dd/yy) _____

Has the patient failed an 8-week trial of high dose proton pump inhibitor? ☐ Yes ☐ No

Has the patient failed a trial of Jorveza or a topical corticosteroid? ☐ Yes ☐ No

Ensure the Drug and Treatment History chart is completed.

Will Dupixent be used in combination with another biologic (e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab), Tezspire (tezepelumab), Xolair (omalizumab))? ☐ Yes ☐ No

Renewals:

Dysphagia Symptom Questionnaire (DSQ) score: _____ Date assessed (mm/dd/yy) _____

Has the patient achieved a histological remission (peak esophageal intraepithelial eosinophil count ≤6 eos/hpf)? ☐ Yes ☐ No

Please provide biopsy report of eosinophilia count.

Will Dupixent be used in combination with another biologic (e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab), Tezspire (tezepelumab), Xolair (omalizumab))? ☐ Yes ☐ No

Prurigo Nodularis

Has the patient had a diagnosis of PN for ≥3 months? ☐ Yes ☐ No

Does the patient have ≥20 PN lesions in total on both legs, and/or both arms and/or trunk? ☐ Yes ☐ No

Have the following causes of PN been investigated and ruled out (select all that apply)?:

- ☐ Medication-induced prurigo nodularis
- ☐ Prurigo nodularis secondary to a non-dermatologic condition (e.g., neuropathy or psychiatric illness)

Has phototherapy been trialed for this patient? ☐ Yes ☐ No

If not, please advise on why: _____

Has the patient tried and failed a ≥2 week course of medium-potency to superpotent topical corticosteroids? ☐ Yes ☐ No

If no, please provide details as to why medium-potency to superpotent topical corticosteroids have not been tried.

Will Dupixent be used in combination with another biologic agent/JAK inhibitor (e.g., Adtralza, Cibinqo, Rinvoq, Olumiant)? ☐ Yes ☐ No

Ensure the Drug and Treatment History chart is completed.

Renewals:

Is the patient receiving a positive clinical response from Dupixent? ☐ Yes ☐ No

If yes, select all that apply:

- ☐ reduced nodular lesion count
- ☐ decreased pruritis
- ☐ reduced nodular lesion size
- ☐ Other: _____

Will Dupixent be used in combination with another biologic agent/JAK inhibitor (e.g., Adtralza, Cibinqo, Rinvoq, Olumiant)? ☐ Yes ☐ No

Other condition (Health Canada approved)

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

Off-label use

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.

Physician Information
Dupixent (dupilumab)

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.

Mail to:
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