Drug Prior Authorization Form
Humira (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.

Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to www.canadalife.com or write to Canada Life's Chief Compliance Officer.

I authorize Canada Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient assistance programs or other benefits programs, other organizations, or service providers working with Canada Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. 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.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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.

Plan Member's signature: _____ Date: _____

Form Completion Instructions:

1. **Complete "Patient Information" sections.**
2. **Have the prescribing physician complete the "Physician Information" sections.**
3. **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

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

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

For additional information regarding Prior Authorization and Health Case Management, please visit our Canada Life website at www.canadalife.com or contact Group Customer Contact Services at 1-800-957-9777.

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Patient Information
Humira (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: _____

Tell us if you have been on this drug before

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)

Tell us if you have coverage with any other benefits plan

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:

_____

_____

Tell us about any Provincial or other coverage you may have

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

Tell us about any Patient Assistance Program you might be enrolled in

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

If Yes, please provide the following information:

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

   Contact Name: _____ Phone Number: _____

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Physician Information
Humira (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.

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. Health Canada indication (include date of initial diagnosis) (MM/YYYY): _____

- ☐ Ankylosing Spondylitis
  - ☐ 40mg every other week
- ☐ Crohn's Disease
  - ☐ Pediatric: 160mg week 0, 80mg on week 2, 20mg on week 4 and every other week thereafter
  - ☐ 160mg week 0, 80mg on week 2, then 40mg on week 4 and every other week thereafter

  Renewal: ☐ 20mg OR ☐ 40mg every other week
- ☐ Hidradenitis Suppurativa
  - ☐ 160mg week 0, 80mg on week 2, then 40mg on week 4 and weekly thereafter
  - ☐ Renewal: 40mg weekly
  - ☐ 80mg week 0, 40mg week 1 and every other week thereafter
  - ☐ Renewal: 40mg every other week
- ☐ Non-infectious Uveitis
  - ☐ 80mg on week 0, then 40mg on week 1 and every other week thereafter
- ☐ Polyarticular Juvenile Idiopathic Arthritis
  - ☐ _____ mg every other week
- ☐ Psoriasis
  - ☐ 80mg on week 0, then 40mg on week 1 and every other week thereafter
  - ☐ Renewal: 40mg every other week
- ☐ Psoriatic Arthritis
  - ☐ 40mg every other week
- ☐ Rheumatoid Arthritis
  - ☐ 40mg every other week
- ☐ Ulcerative Colitis
  - ☐ 160mg week 0, 80mg on week 2, then 40mg on week 4 and every other week thereafter
  - ☐ Renewal: 40mg every other week

Any other dosage regimen and rationale for alternate dosing: _____

Complete questions 1-4 and Physician's information

☐ Other (approved by Health Canada): _____

Dosage and Regimen: _____

Complete questions 1-5 and Other condition (Health Canada approved)

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

Dosage and Regimen: _____

Complete questions 1-5 and Off-label use

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Physician Information
Humira (adalimumab)

Physician's Information *(continued)* (please print)

Patient's weight: _____ kg (for weight-based dosing)

Date determined (MM/YYYY): _____

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

3. Where will treatment be administered? ☐ Home ☐ Physician's Office ☐ Private clinic ☐ Hospital in-patient ☐ Hospital out-patient

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

_____

_____

5. 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

Provide diagnostic imaging report of SI joint with interpretation	Current BASDAI score and date (DD/MM/YYYY)
Back pain present? ☐ Yes ☐ No If yes, indicate length and time present: _____	_____

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:

If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

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Physician Information
Humira (adalimumab)

Hidradenitis Suppurativa

☐ Moderate to severe

Please state the current Hurley stage of patient's HS lesions: _____

What is the patient's current total abscess and inflammatory nodule (AN) count? _____

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:

If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

Inflammatory Bowel Disease

Was Humira started while the patient was in the hospital? ☐ Yes ☐ No

Ulcerative Colitis

☐ Moderate ☐ Severe

Current MAYO score ≥6: ☐ Yes ☐ No

Endo Subscore: _____

Crohn's Disease

☐ Moderate ☐ Severe

Current HBI: _____ (DD/MM/YYYY)

OR Current CDAI: _____ (DD/MM/YYYY)

Required Documentation for both Ulcerative Colitis and Crohn's Disease provide:

ESR: _____ (DD/MM/YYYY)

CRP: _____ (DD/MM/YYYY)

Site of the disease and complications of Ulcerative Colitis or Crohn's Disease:

Required for all applications:

For inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease): include daily steroid dose on medical chart.

Non-Infectious Uveitis

Check 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 details:

☐ Patient has failed or has contraindications to an ant-metabolic or calcineurin inhibitor treatment

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Physician Information
Humira (adalimumab)

Polyarticular juvenile idiopathic arthritis

Is the patient's disease moderately to severely active? ☐ Yes ☐ No

Will the patient use Humira in combination with methotrexate? ☐ Yes ☐ No

Is the patient unable to receive or has a clinical contraindication to methotrexate? ☐ Yes ☐ No

If yes, please explain: _____

Has the patient failed at least a 12-week trial of a DMARD? ☐ Yes ☐ No

Psoriasis

%BSA	Areas of Body involved
Thickness of plaques	Current results and date of both of the following (DD/MM/YYYY) _____ DLQI _____ PASI _____

Drug(s) and Treatment(s) past and present	Dosing Regimen	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Clinical Results/Outcome
Methotrexate				☐ Failure ☐ Intolerance ☐ Other Clinical details:
Acitretin				☐ Failure ☐ Intolerance ☐ Other Clinical details:
Cyclosporine				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

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Physician Information
Humira (adalimumab)

Psoriatic Arthritis

Swollen joint count

Current results and date of one of the following (DD/MM/YYYY) _____

CDAI _____ DAS28 _____ HAQ _____

Results of the following and date (DD/MM/YYYY)

ESR _____

CRP _____

Drug(s) and Treatment(s) past and present	Dosing Regimen	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Clinical Results/Outcome
Methotraxate				☐ Failure ☐ Intolerance ☐ Other Clinical details:
Leflunomide				☐ Failure ☐ Intolerance ☐ Other Clinical details:
Sulfasalazine				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

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Physician Information
Humira (adalimumab)

Rheumatoid Arthritis

Swollen joint count

Current results and date of one of the following (DD/MM/YYYY) _____

CDAI _____ DAS28 _____ HAQ _____

Results of the following and date (DD/MM/YYYY)

ESR _____

CRP _____

Drug(s) and Treatment(s) past and present	Dosing Regimen	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Clinical Results/Outcome
Methotrexate				☐ Failure ☐ Intolerance ☐ Other Clinical details:
Leflunomide				☐ Failure ☐ Intolerance ☐ Other Clinical details:
Sulfasalazine				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

Other condition (Health Canada approved)

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

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Physician Information
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Off-label use

Questions 1-5 must be completed.

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 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: _____

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

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

Fax to: **The Canada Life Assurance Company**
Fax 1-204-946-7664
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