



Drug Prior Authorization Form Xolair (omalizumab)

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

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 www.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 at 711 for TTY to Voice or 1-800-855-0511 for Voice to TTY.

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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 declination:

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 declination: _____

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: _____

(Continued on next page)

**Physician Information
Xolair (omalizumab)**

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. Prescribed subcutaneous dose requested:

Asthma		Chronic Urticaria
Every 2 weeks	Every 4 weeks	Every 4 weeks
<input type="checkbox"/> 75mg	<input type="checkbox"/> 75mg	<input type="checkbox"/> 150mg
<input type="checkbox"/> 150mg	<input type="checkbox"/> 150mg	<input type="checkbox"/> 300mg
<input type="checkbox"/> 225mg	<input type="checkbox"/> 225mg	
<input type="checkbox"/> 300mg	<input type="checkbox"/> 300mg	
<input type="checkbox"/> 375mg	<input type="checkbox"/> 375mg	

Other (please specify): _____

Provide rationale: _____

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

Moderate to severe allergic asthma

Chronic Idiopathic Urticaria

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 the 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 alternative drug in the same therapeutic class:

**Physician Information
Xolair (omalizumab)**

Physician's Information (please print) (continued)

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
				<input type="checkbox"/> Failure <input type="checkbox"/> Intolerance <input type="checkbox"/> Other Clinical details: _____ _____
				<input type="checkbox"/> Failure <input type="checkbox"/> Intolerance <input type="checkbox"/> Other Clinical details: _____ _____
				<input type="checkbox"/> Failure <input type="checkbox"/> Intolerance <input type="checkbox"/> Other Clinical details: _____ _____

Moderate to severe persistent Asthma Initial

Asthma History and Severity

The patient's asthma severity is currently classified as:

- Moderate Severe

Does the patient have a confirmed positive skin test or in vitro reactivity to a perennial aeroallergen?

- Yes. Date determined (DD/MM/YYYY): _____ No

Indicate all the current asthma controllers required ****Medication Chart must be completed****

- Continuous high-dose inhaled steroids ICS
 Continuous medium-high dose ICS plus long-acting inhaled beta-agonist (LABA)

Asthma Control

Does the patient's asthma remain uncontrolled despite treatment? Yes No

Over the previous 6 months, the patient's use of rescue inhalers has been:

- Stable Increasing

Indicate the number of times the patient has experienced asthma symptoms over the previous month.

Daytime symptoms (_____)

Night time symptoms (_____)

Missed school or work due to asthma (_____)

How many asthma exacerbations has the patient experienced over the previous 12 months, which required an urgent physician visit or emergency department visit? _____

Physician's Information (please print) (continued)

Xolair Dose Assignment

Question 1 must be completed.

Current weight (kg) _____ Date determined (DD/MM/YYYY): _____

Pretreatment serum total IgE (IU/mL) _____ ****Copy of lab report must be submitted****

Moderate to severe persistent Asthma Renewal

Date Xolair (omalizumab) was established (DD/MM/YYYY): _____

Current Dose and frequency (_____) mg every (_____) weeks

Since starting treatment with Xolair have the patient's use of rescue inhalers been stable or decreased? Yes No

Please complete the medication chart with all current asthma medications **** Chart must be completed ****

Have the patient's asthma symptoms been controlled over the previous 6 months? Yes No

Indicate the number of times the patient has experienced asthma symptoms over the previous month

Daytime symptoms (_____)

Night time symptoms (_____)

Missed school or work due to asthma (_____)

How many asthma exacerbations has the patient experienced over the previous 12 months, which required an urgent physician visit or emergency department visit? _____

Chronic Idiopathic Urticaria

Is the patient symptomatic despite use of maximum recommended doses of H1-antihistamine therapy? Yes No

Complete medication chart on the previous page.

Other condition (Health Canada approved)

Please 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 Xolair? 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 alternative 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.



Physician Information Xolair (omalizumab)

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

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