THE Great-West Life ASSURANCE COMPANY

Drug Prior Authorization Form
Adcetris (brentuximab vedotin)

The purpose of this form is to obtain information required to assess your drug claim. For additional information regarding Prior Authorization and Health Case Management, please visit our Great-West Life website at www.greatwestlife.com.

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.

Great-West 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 Great-West Life's personal information policies and practices (including with respect to service providers), refer to www.greatwestlife.com or write to Great-West Life's Chief Compliance Officer.

I authorize Great-West 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 Great-West 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 Great-West Life to assess my claim and that refusing to consent may result in delay or denial of my claim. Great-West 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 Great-West 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 Great-West Life Assurance Company**
Drug Services
PO Box 6000
Winnipeg MB R3C 3A5

Email to: **gwldrug.services@gwl.ca**
Attention: Drug Services

Fax to: **The Great-West Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Services

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THE Great-West Life ASSURANCE COMPANY

Patient Information
Adcetris (brentuximab vedotin)

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 Adcetris? ☐ Yes ☐ No

If Yes, a) indicate start date (DD/MM/YYYY): _____

b) coverage provided by: _____

(if coverage is not provided by Great-West Life please provide pharmacy print-out showing purchase of Adcetris)

Tell us if you have coverage with any other benefits plan

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

If Yes, name of other insurance company: _____

If other plan is with Great-West 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 Adcetris 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 Adcetris? ☐ 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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THE Great-West Life ASSURANCE COMPANY

Physician Information
Adcetris (brentuximab vedotin)

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 dosage and regimen:

   ☐ _____ mg/kg every _____ weeks

   Number of vials per dose requested: _____

   ☐ Other (please specify): _____

   Provide rationale: _____

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

   Date determined (MM/YYYY):_____

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

   ☐ Hodgkin Lymphoma - stage IV previously untreated

   ☐ Hodgkin Lymphoma - autologous stem cell transplant (ASCT) failure

   ☐ Hodgkin Lymphoma - Post-autologous stem cell transplant (ASCT) consolidation

   ☐ Post- autologous stem cell transplant (ASCT) consolidation treatment of Hodgkin Lymphoma (HL)

   ☐ Primary cutaneous anaplastic large cell lymphoma (pcALCL) or mycosis funoides (MF)

   ☐ Systemic Anaplastic Large Cell Lymphoma (sALCL)

   ☐ Other (approved by Health Canada): _____

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

   Is this drug being prescribed in accordance with approved Health Canada indications[1]?

   ☐ Yes, complete questions 1 - 6 and Physician's Information

   ☐ No, prescribed use is not approved by Health Canada: _____

   Complete questions 1 – 6 and Off-label use

[1]Approved Health Canada Indications and Clinical Use for Adcetris:

- The treatment of patients with Hodgkin lymphoma (HL) after failure of autologous stem cell transplant (ASCT) or after failure of at least two multi-agent chemotherapy regimens in patients who are not ASCT candidates, has been issued marketing authorization with conditions, pending the results of trials to verify its clinical benefit.
- The treatment of patients with systemic anaplastic large cell lymphoma (sALCL) after failure of at least one multi-agent chemotherapy regimen, has been issued marketing authorization with conditions, pending the results of trials to verify its clinical benefit.
- The treatment of previously untreated patients with Stage IV Hodgkin lymphoma (HL) in combination with doxorubicin, vinblastine, and dacarbazine (AVD).
- The post-ASCT consolidation treatment of patients with HL at increased risk of relapse or progression.
- The treatment of adult patients with primary cutaneous anaplastic large cell lymphoma (pcALCL) or CD30-expressing mycosis fungoides (MF) who have prior systemic therapy

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Physician Information
Adcetris (brentuximab vedotin)

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

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 Adcetris has been prescribed instead of an alternative drug in the same therapeutic class.

Genetic test results are not required

_____

_____

6. Drug and Treatment History – **must be completed for every request.**

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:

Hodgkin Lymphoma- Stage IV previously untreated- Genetic test results are not required

Has the patient received previous treatment for advanced-stage Hodgkin Lymphoma? ☐ Yes ☐ No

Will patient be using Adcetris in combination with doxorubicin, vinblastine, and dacarbazine? ☐ Yes ☐ No

Hodgkin Lymphoma autologous stem cell transplant (ASCT) failure – Genetic test results are not required

Has the patient failed previous autologous stem cell transplant (ASCT)? ☐ Yes ☐ No

Please indicate the date on which ASCT was received (DD/MM/YYYY): _____

Has the patient failed two or more prior multi-agent chemotherapy regimens? ☐ Yes ☐ No

Please detail in medication chart provided above.

Please provide the patient's ECOG score: _____

Date score obtained (DD/MM/YYYY) _____

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

Hodgkin Lymphoma- Post-autologous stem cell transplant (ASCT) consolidation - Genetic test results are not required

Will Adcetris be used as monotherapy for consolidation treatment ? ☐ Yes ☐ No

Has the patient received autologous stem cell transplant (ASCT) within the past 4-6 weeks? ☐ Yes ☐ No

Please clearly indicate the start and stop dates of ASCT received and patient's response in the medication chart provided on the previous page.

Please indicate the patient's response to the pre-transplant salvage chemotherapy the patient has received:

☐ Complete remission

☐ Partial remission

☐ Stable disease

Please check all that apply to the patient:

☐ Primary refractory HL (failure to achieved complete remission)

☐ Relapsed HL with an initial remission (<12 months)

☐ Extranodal involvement at the start of pre-transplant salvage chemotherapy

Has the patient had previous exposure to Adcetris? ☐ Yes ☐ No

Please provide the patient's ECOG score: _____

Date score obtained (DD/MM/YYYY): _____

Primary cutaneous anaplastic large cell lymphoma (pcALCL) or mycosis fungoides (MF) - Genetic test results are not required

If diagnosis of mycosis fungoides (MF), has patient received one or more systemic therapies? ☐ Yes ☐ No

If diagnosis of primary cutaneous anaplastic large cell lymphoma (pcALCL), has the patient received prior radiation or one or more systemic therapies? ☐ Yes ☐ No

Please ensure medication chart is complete.

Systemic Anaplastic Large Cell Lymphoma (sALCL) – Genetic test results are not required

Has the patient failed one or more prior multi-agent chemotherapy? ☐ Yes ☐ No

Please detail in medication chart provided on the previous page

Please provide the patient's ECOG score: _____

Date score obtained (DD/MM/YYYY): _____.

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

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

_____

_____

THE Great-West Life ASSURANCE COMPANY

Physician Information
Adcetris (brentuximab vedotin)

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 Adcetris? ☐ 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 Adcetris 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.

_____

Note for Physician: To be eligible for reimbursement, Great-West Life may require your patient to purchase a drug requiring prior authorization from a pharmacy designated by Great-West 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 Great-West 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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Drug Services
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: **The Great-West Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Services

Email to: **gwldrug.services@gwl.ca**
Attention: Drug Services

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