THE Great-West Life ASSURANCE COMPANY

Drug Prior Authorization Form
Chronic Hepatitis C
Daklinza, Epclusa, Galexos, Harvoni, Holkira Pak, Maviret, Sovaldi, Sunvepra, Technivie, Zepatier

The purpose of this form is to obtain information required to assess your drug claim. Approval for coverage of this drug may be reassessed at any time at Great-West Life's discretion. 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

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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Patient Information
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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 Great-West 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 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 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
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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. Is this drug being prescribed according to the Health Canada Product Monograph? ☐ Yes ☐ No

   If yes, complete the regimen chart below, question 2, Measures of Liver Disease, and Previous Treatments.

   If no, complete the regimen chart below, question 2, Measures of Liver Disease, Previous Treatments, and Off-Label Use.

   Genetic test results are not required

Preferred Regimens	Duration
☐ Maviret 100/40mg 3 tablets daily	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks

Other Regimens

Please detail why the preferred regimen cannot be used: (Genetic test results are not required)

☐ Alternate regimen is being prescribed in accordance with provincial coverage. (BC, SK, and MB only)

☐ Other: ____________________

Drug Requested	In combination with?	Duration
☐ Daklinza 60mg daily	☐ ribavirin x ________ weeks	☐ 8 weeks
☐ Epclusa 400mg/100mg daily	☐ peginterferon x ________ weeks	☐ 12 weeks
☐ Galexos 150mg daily	☐ sofosbuvir	☐ 16 weeks
☐ Harvoni 90mg/400mg daily	☐ daclatasvir	☐ 24 weeks *Please see page 4
☐ Holkira Pak as directed	☐ no combination therapy	
☐ Sovaldi 400mg daily		
☐ Sunvepra 100mg twice daily		
☐ Technivie 1.5/75/50mg as directed		
☐ Zepatier 50mg/100mg daily		

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

* Please provide medical rationale why the requested treatment duration is 24 weeks instead of an alternate treatment of shorter duration:
Genetic test results are not required

____

____

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

Measures of Liver Disease *Required for all requests* – Genetic test results are not required

Fibrosis Score: ______________________ Date (DD/MM/YYYY): ______________________

Include Fibrosis Stage Report and completed calculations and reference values as needed.

Child-Pugh Score: ☐ A ☐ B ☐ C Date (DD/MM/YYYY): ______________

Does the patient have the following?

Compensated cirrhosis ☐ Yes ☐ No

De-compensated cirrhosis ☐ Yes ☐ No

Suspected or confirmed hepatocellular carcinoma ☐ Yes ☐ No

History of liver transplant ☐ Yes Date of transplant (DD/MM/YYYY): ______________ ☐ No

Any other condition that may affect the expected progression of their disease or their response to treatment?

☐ Yes, provide details below. ☐ No

____

____

Additional Clinical Information *Required for all requests* – Genetic test results are not required

Please provide date of hepatitis C infection diagnosis (DD/MM/YYYY): ______________________

Has the patient been diagnosed with acute hepatitis C infection within the last 6 months? ☐ Yes ☐ No

Does the patient otherwise have an anticipated survival beyond 1 year from application? ☐ Yes ☐ No

Previous Treatments – Genetic test results are not required

Has the patient been treated with any previous Hepatitis C therapy (including direct acting antivirals)? ☐ Yes ☐ No

Is this a request for re-treatment? ☐ Yes ☐ No

Fill out the medication chart below.

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:

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

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

____

____

Off-label use – Genetic test results are not required

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, 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