THE Great-West Life ASSURANCE COMPANY

Drug Prior Authorization Form
Lynparza (olaparib)

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

(Continued on next page)

M6453(LYNPARZA)-5/19

THE Great-West Life ASSURANCE COMPANY

Patient Information
Lynparza (olaparib)

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 Lynparza? ☐ 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 Lynparza)

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 Lynparza 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 Lynparza? ☐ 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)

THE Great-West Life ASSURANCE COMPANY

Physician Information
Lynparza (olaparib)

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:
   - ☐ 400mg twice daily
   - ☐ 300mg twice daily
   - ☐ Other (please specify): _____

   Provide rationale: _____

2. Health Canada indication (include date of initial diagnosis) (MM/YYYY): _____
   - ☐ Ovarian, Fallopian Tube, or Peritoneal Cancer
   - ☐ Metastatic Breast Cancer
   - ☐ 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, condition not approved by Health Canada: _____

Complete questions 1-6 and Off-Label use

[1]Approved Health Canada Indications and Clinical Use for Lynparza

- Monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed (PSR) BRCA wild type high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete response or partial response) to platinum-based chemotherapy, has been issued marketing authorization with conditions, pending the results of trials to verify its clinical benefit.

- Monotherapy for the maintenance treatment of adult patients with advanced BRCA-mutated high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete response or partial response) to first-line platinum-based chemotherapy. Patients must have confirmation of BRCA mutation (identified by either germline or tumour testing) before Lynparza treatment is initiated.

- Monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed (PSR) BRCA-mutated high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete response or partial response) to platinum-based chemotherapy.

- Monotherapy for the treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm), human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer who have previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. Patients with hormone receptor (HR)- positive breast cancer should have progressed on or be considered inappropriate for endocrine therapy. Germline BRCA mutation must be confirmed before LYNPARZA treatment is initiated.

(Continued on next page)

THE Great-West Life ASSURANCE COMPANY

Physician Information
Lynparza (olaparib)

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 Lynparza has been prescribed instead of an alternate 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:

Ovarian, Fallopian Tube or Peritoneal Cancer – Genetic test results are not required

How many regimens of platinum-based chemotherapy has the patient completed? _____

Provide details in medication chart

Is Lynparza being prescribed as monotherapy? ☐ Yes ☐ No

Is the patient currently in response (complete response or partial response) to platinum-based chemotherapy? ☐ Yes ☐ No

If patient has received more than one regimen of platinum-based chemotherapy, has platinum sensitivity been confirmed? (defined as disease progressing at least 6 months after completion of the penultimate platinum chemotherapy) ☐ Yes ☐ No

Breast Cancer – Genetic test results are not required

Has the patient received prior treatment with anthracycline- and a taxane- containing regimen in adjuvant or metastatic setting? ☐ Yes ☐ No

Has the patient received prior endocrine therapy, if deemed appropriate for endocrine therapy? ☐ Yes ☐ No

Has the patient progressed with platinum-based therapy? ☐ Yes ☐ No

Has the patient received more than 2 prior lines of chemotherapy in the metastatic setting? ☐ Yes ☐ No

Has the patient had prior treatment with other PARP inhibitors? ☐ Yes ☐ No

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
Lynparza (olaparib)

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 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 Lynparza 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.

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

Clear