# DRUG SPECIAL AUTHORIZATION REQUEST FORM, PREFERRED PHARMACY NETWORK, AND ADHERENCE SUPPORT PROGRAM INFORMATION

## COMPLETING YOUR FORM…

To ensure prompt processing of your request, please complete the following Special Authorization Request Form in full. Note that there are sections that must be completed by you, the patient, and sections that must be completed by **your prescriber**. Once completed, submit the form to Green Shield Canada (GSC) via your method of choice:

**By email:** drugspecial.autho@greenshield.ca

**By fax:** 1.866.797.6483

**By mail:** Green Shield Canada, Drug Special Authorization Department
P.O. Box 1606, Windsor ON N9A 6W1

**Note that submission of an incomplete form may result in delays.**

Your request will be reviewed and evaluated by our Drug Special Authorization Department who will share the results with you. Should you have any questions, call GSC's Contact Centre at 1.888.711.1119.

## OTHER DRUG COVERAGE...

If you are eligible for coverage by another plan (public or private), indicate that in Section 1B of the authorization form.

If you have provincial drug coverage, please ensure that your prescriber has applied for coverage under your primary provincial drug plan. The result of that application must be attached to the completed Special Authorization Request Form.

## PREFERRED PHARMACY NETWORK (PPN)

If your request for coverage is approved, you may be required to obtain your special authorization drug at an approved pharmacy. If this applies to your benefits plan, a care coordinator working on behalf of GSC will contact you to help you find an approved pharmacy near you. The care coordinator will also work with you and your physician to arrange to have your prescription sent to the pharmacy you select.

Should you choose not to speak with the care coordinator, and you obtain your special authorization drug at an unapproved pharmacy, your claim may not be paid under your benefits plan.

## ADHERENCE SUPPORT PROGRAM

Some drug treatment plans are complicated, and patients can sometimes find it difficult to follow their prescriber's instructions when taking their medication. If your special authorization drug is approved, you may be eligible for adherence support services. A medication management specialist can work with you to ensure that you have the support necessary to take your medication as instructed and adhere to your drug treatment plan.

# PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM

**Please note: Incomplete information may delay your request for processing.**

## SECTION 1A – PATIENT INFORMATION

| First Name | | Green Shield ID | Employer Name |
|---|---|---|---|
| Last Name | | Date of Birth (YYYY/MM/DD) | Email Address |
| Street Address | | | Telephone (Home) |
| City | Province | Postal Code | Telephone (Mobile) |

## SECTION 1B - COORDINATION OF BENEFITS

**Patient Support Program**

Is the patient enrolled in any assistance program for the requested drug? ☐ Yes ☐ No

| Program Name | | | Patient Identifier |
|---|---|---|---|
| Contact First Name | Contact Last Name | Contact Phone | Contact Email |

**Drug Access Navigator**

Is the patient in contact with an alternate drug access navigator (i.e., hospital)? ☐ Yes ☐ No

| Organization Name | | | |
|---|---|---|---|
| Contact First Name | Contact Last Name | Contact Phone | Contact Email |

**Provincial Coverage**

Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ NA

What is the coverage decision? (Attach decision outcome letter) ☐ Approved ☐ Denied

**Other Private Coverage**

Is this patient covered by any other plan? (If yes answer below) ☐ Yes ☐ No ☐ NA

| Planholder First Name | Planholder Last Name | Date of Birth (YYYY/MM/DD) |
|---|---|---|

Relationship to Planholder ☐ Self ☐ Spouse ☐ Dependant ☐ Other _____

What is the coverage decision? (Attach outcome letter if received) ☐ Approved ☐ Denied

## SECTION 1C – CONSENT

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, patient assistance program, clinic, or medically related facility to provide to Green Shield Canada information regarding my health as it relates to this request. I hereby authorize Green Shield Canada to obtain and exchange personal information with other parties as required, including any health care provider, patient assistance program and/or preferred pharmacy network (PPN) vendor working with Green Shield Canada for the purpose of administering this benefit. I acknowledge that my personal information is needed to assess eligibility for this drug, to administer the group benefits plan, and where applicable, to administer pharmacy preferred provider network and patient support programs on my behalf. I acknowledge that my personal information may be exchanged and transferred between these parties for these purposes and may include information about my drug claims, diagnosis, medical condition, treatment, and other health related information. I acknowledge that providing my consent will help Green Shield Canada to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instructions to that effect at the address indicated below.

I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada only when the information is needed to administer this benefit and/or to confirm the accuracy of this information. I certify that the information given is true, correct, and complete to the best of my knowledge.

| **Signature of Patient** | **Date (YYYY/MM/DD)** |
|---|---|

If under 16 years of age (14 years of age in Quebec), the signature of the parent / guardian is required.

**PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM**

# BIOLOGICS – TREATMENT OF PSORIASIS

## SECTION 2A – DRUG REQUESTED FOR EVALUATION

| | |
|---|---|
| Product Name and Strength | |
| Dose | Frequency of Administration |
| Route (ex. oral, IV, etc.) | Therapy Duration |

Is the patient currently on the requested therapy? (If yes provide therapy start date) ☐ Yes ☐ No Therapy Start Date (YMD) _____

If already established on therapy, please attach proof of payment and details of prior coverage. Individuals established on therapy through compassionate coverage will only be considered if they met GSC criteria on initiation of therapy.

## SECTION 2B – LOCATION OF ADMINISTRATION

☐ Home
☐ Physician's Office
☐ Hospital (In-Patient)
☐ Hospital (Out-Patient)
☐ Infusion Center

**For Infusion Centers please complete information below**

| Name and Address of Infusion Center | | |
|---|---|---|
| City | Province | Postal Code |

## SECTION 2C – DRUG REQUESTED FOR EVALUATION

**Please confirm the drug you are requesting for evaluation by checking off the box next to the drug**

**Category 1:**

| | |
|---|---|
| Adalimumab | ☐ Abrilada ☐Amgevita ☐Hadlima ☐Hulio ☐*Humira ☐Hyrimoz ☐Idacio ☐Simlandi ☐Yuflyma |
| Bimekizumab | ☐ Bimzelx |
| Brodalumab | ☐ Siliq |
| Certolizumab | ☐ Cimzia |
| Deucravacitinib | ☐ Sotyktu ***Please note restrictions will enforce a maximum dose of 6 mg per day*** |
| Etanercept | ☐ Brenzys ☐ *Enbrel ☐ Erelzi |
| Guselkumab | ☐ Tremfya |
| Infliximab | ☐ Avsola ☐ Inflectra ☐ *Remicade ☐ Renflexis |
| Risankizumab | ☐ Skyrizi |
| Secukinumab | ☐ Cosentyx |
| Tildrakizumab | ☐ Ilumya |
| Ustekinumab | ☐ Stelara SC |

**Category 2:**

| | |
|---|---|
| Ixekizumab | ☐ Taltz |

**Pediatric Category 1:**

| | |
|---|---|
| Etanercept | ☐ Brenzys ☐*Enbrel ☐ Erelzi |
| Secukinumab | ☐ Cosentyx |
| Ustekinumab | ☐ Stelara SC |

**Pediatric Category 2:**

| | |
|---|---|
| Ixekizumab | ☐ Taltz |

***Coverage will be provided based on your current plan guidelines.**

**PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM**

# BIOLOGICS – TREATMENT OF PSORIASIS

The above list of drugs will be considered for reimbursement in numerical order as category 1, category 2, etc. as indicated by sequenced numbering within the disease category. A category 2 drug will only be reimbursed after an adequate trial or adverse effects of two category 1 drugs.

*Note: Patients will not be permitted to switch back to a previously trialed biologic agent if they were originally deemed ineffective therapy*

**Initial Approvals (12 months):**

For use in moderate to severe psoriasis defined as PASI≥10 and/or BSA≥10% (or BSA≥5% if involves hands, feet, face or genitals) in patients ≥ 4 years of age.

Current PASI score:_____ Date PASI conducted:_____

Current BSA score:_____ Date BSA conducted:_____

If BSA <10%, please clarify areas involved:_____

Weight: _____

Prior failed therapy must include potent topical agents, phototherapy, and a prior oral systemic agent at therapeutic dose;

Topical agents trialed and timeframes of use:

Patient failed to respond, is intolerant, or is unable to access UV phototherapy.

☐ Lack of effect

Resulting PASI or BSA:_____

☐ Intolerance or inaccessibility

Nature of intolerance or reason for inaccessibility:

Continued …

**PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM**

# BIOLOGICS – TREATMENT OF PSORIASIS

Patient has failed to respond to one of the below medications or has experienced specific intolerances or specific contraindications to both of the following medications (relevant supporting documentation must be provided in the case of intolerances or contraindications);

☐ Methotrexate:

☐ Lack of effect

Highest tolerated dose used:_____ Timeframe of use:_____

Resulting PASI or BSA:_____

If less than 20mg weekly (15 mg for ages >65) for 3 months please provide rationale

☐ Intolerance or contraindication (provide copies of supporting documentation)

☐ Acitretin:

☐ Lack of effect

Highest tolerated dose used:_____ Timeframe of use:_____

Resulting PASI or BSA:_____

If less than 50mg daily for 3 months please provide rationale

☐ Intolerance or contraindication (provide copies of supporting documentation)

When switching to a new biologic, please provide current PASI and additional rationale for new treatment plan:

**Renewals (24 months):**

Must achieve a reduction of 50% in either PASI or BSA from baseline.

Current PASI:_____ OR Current BSA:_____

## PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM

**Please note: Incomplete information may delay your request for processing.**

| **SECTION 3A – PRESCRIBER INFORMATION AND SIGNATURE** | | |
|---|---|---|
| First Name | License Number | Specialty |
| Last Name | Telephone | Fax |
| Street Address | | |
| City / Province | | Postal Code |
| **Signature** | | **Date (YYYY/MM/DD)** |

| **SECTION 3B – SUBMISSION INSTRUCTIONS** | |
|---|---|
| Return request form along with any original paid "Official Pharmacy" receipts to : | |
| **Fax** : 1.519.739.6483 or 1.866.797.6483<br>**Email** : drugspecial.autho@greenshield.ca | **Mail**: Green Shield Canada<br>Drug Special Authorization Department,<br>P.O. Box 1606, Windsor ON N9A 6W1 |

**COST OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.**