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 ULCERATIVE COLITIS

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:

Adalimumab ☐ Abrilada ☐ Amgevita ☐ Hadlima ☐ Hulio ☐*Humira ☐ Hyrimoz ☐ Idacio ☐ Simlandi ☐ Yulfyma

Golimumab ☐ Simponi

Infliximab ☐ Avsola ☐ Inflectra ☐*Remicade ☐ Renflexis

Ozanimod ☐ Zeposia

Ustekinumab ☐ Stelara

Vedolizumab ☐ Entyvio

Pediatric

Adalimumab ☐ Abrilada ☐ Amgevita ☐ Hulio ☐ *Humira ☐ Hyrimoz

Infliximab ☐ Avsola ☐ Inflectra ☐*Remicade ☐ Renflexis

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

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

Initial Approval (12 months):

☐ For use in moderate to severe active ulcerative colitis in patient ≥ 6 years of age and a Mayo score of 6 to 12 with endoscopic sub-score ≥ 2;

Mayo score:_____Endoscopic sub-score:_____Rectal bleeding sub-score:_____

AND

☐ Physician is a gastroenterologist or is experienced in the management of ulcerative colitis;

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM

BIOLOGICS – TREATMENT OF ULCERATIVE COLITIS

AND

☐ Has had an inadequate response, loss of response to, has medical contraindication OR was intolerant to a corticosteroid or an immunosuppressant.

Names, dates, duration and side effects of prior corticosteroid treatment

Reason(s) for discontinuing corticosteroid treatment

Names, dates, duration and side effects of prior immunosuppressant treatment:

Reason(s) for discontinuing immunosuppressant treatment

When switching to a new biologic, please provide documentation on inadequate response, loss of response to, or intolerance to current biological agent treatment:

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BIOLOGICS – TREATMENT OF ULCERATIVE COLITIS

Renewal Criteria (24 months):

Must achieve a reduction of ≥ 3 points and ≥ 30% in their Mayo score from baseline AND either a decrease from baseline in the endoscopic sub-score of ≥ 1 or a rectal bleeding sub-score of 0 or 1.

	Baseline	Current
Mayo score		
Endoscopic sub-score		
Rectal bleeding sub-score		

Note: A reassessment every 12 months will be required and criteria must be maintained if therapy remains necessary.

Additional comments pertaining to medication/medical condition:

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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 **Email** : drugspecial.autho@greenshield.ca	**Mail**: Green Shield Canada Drug Special Authorization Department, P.O. Box 1606, Windsor ON N9A 6W1

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