PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For biologic response modifier therapy: Amgevita *(adalimumab)*

Please fax form to: 1-866-840-1509

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by Patient

Employee or Insured's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Insured ❑Employee ❑Spouse ❑Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail	❑ Call me (and leave a message if I'm not there)	❑ Fax me at:
❑ Contact my pharmacy: Pharmacy Name		Pharmacy Phone Number

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

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B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Amgevita (adalimumab)		

***Amgevita (adalimumab)* will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program**. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies one of the following criteria:

- ❑ Ankylosing Spondylitis (9631008): Adult patient has tried and failed conventional treatment (i.e. non-steroidal anti-inflammatory drugs [NSAIDs]),

OR

- ❑ Adult Crohn's Disease (34000006): Patient has tried and failed conventional treatment (i.e. disease-modifying antirheumatic drugs [DMARDs]),

OR

- ❑ Pediatric Crohn's Disease (34000006): Patient (13 to 17 years of age weighing ≥40kg) has tried and failed conventional treatment (i.e. aminosalicylate and/or corticosteroid and/or an immunosuppressant)

OR

- ❑ For the treatment of patients with chronic Plaque Psoriasis (200965009):
  - ❑ The Patient:
    - ❑ Is ≥ 18 years of age; AND
    - ❑ Has > 10% Body Surface Area (BSA) involvement; OR
      - ❑ significant involvement of the face, hands, feet or genital regions; AND
    - ❑ Has a PASI score ≥ 12; OR
      - ❑ significant involvement of the face, hands, feet or genital regions; AND
    - ❑ Has failed to respond, is intolerant to, or unable to access UV phototherapy; AND
    - ❑ Has failed to respond, or has experienced a specific intolerance to, topical therapy and at least one systemic therapy; AND
  - ❑ Prescribing physician is a dermatologist or is experienced in the management of moderate-severe plaque psoriasis

OR

- ❑ Psoriatic Arthritis (156370009): Adult patient has tried and failed conventional treatment (i.e. DMARDs),

OR

- ❑ Rheumatoid Arthritis (69896004): Adult patient has tried and failed a minimum 12 week trial of Methotrexate plus one other disease modifying anti-rheumatic drug (DMARD). Where combinations of non-biologic DMARDs are impossible (a rare situation), 3 consecutive non-biologic DMARDs would be acceptable,

OR

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Eligibility Criteria

- ❑ Polyarticular Juvenile Idiopathic Arthritis (16044751000119106): Patient (2 to 17 years of age) has tried and failed conventional treatment (i.e. DMARDs),

OR

- ❑ Ulcerative Colitis (64766004): Adult patient has tried and failed conventional treatment (including corticosteroids, azathioprine and/or 6-mercaptopurine),

OR

- ❑ Treatment of hidradenitis suppurativa (59393003) in adult and adolescent patients (12 to 17 years of age weighing ≥ 30 kgs), who have not responded to conventional therapy (including systemic antibiotics),

OR

- ❑ Treatment of Non-infectious Intermediate Uveitis, Posterior Uveitis, Panuveitis (T990000027), in patients who are:
  - ❑ 18 years of age or over, with active or inactive disease as follows:
    - ❑ Active disease despite ≥2 weeks of maintenance therapy with oral prednisone at a dose of ≥10 mg/day to ≤60 mg/day (or oral corticosteroid equivalent), AND at least one of the following in one or both eyes:
      - ❑ Active, inflammatory, chorioretinal and/or inflammatory retinal vascular lesion, AND
      - ❑ ≥2+ Anterior chamber (AC) cells grade according to SUN criteria, AND
      - ❑ ≥2+ Vitreous haze (VH) grade according to NEI/SUN criteria

    OR

    - ❑ Inactive disease in patients taking ≥10mg of oral prednisone to maintain this inactive state who are at risk of the long-term side-effects of corticosteroids, AND all of the following for both eyes:
      - ❑ Without active, inflammatory chorioretinal and/or inflammatory retinal vascular lesion, AND
      - ❑ ≤0.5+ AC grade according to SUN criteria, AND
      - ❑ ≤0.5+ VH grade according to NEI/SUN criteria

OR

- ❑ Treatment of chronic non-infectious anterior uveitis associated with juvenile idiopathic arthritis in pediatric patients (T990000028) who:
  - ❑ Between the ages of 2 and 18 years of age, AND:
  - ❑ Have had an inadequate response to conventional therapy (at least 12 weeks of methotrexate treatment), or are intolerant to conventional therapy, or in whom conventional therapy is inappropriate,

OR

- ❑ None of the above applies

Relevant additional information _____

Physician Information

Physician's Name	License Number	Telephone Number	Fax Number

Address	City	Province	Postal Code

Physician's Signature	Date: (DD/MMM/YYYY)
	__ __ / __ __ __ / __ __ __ __