PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For rare diseases: Carbaglu *(carglumic acid)*

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 Member Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient 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 a.m. and 4 p.m. Eastern ime.

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
Carbaglu (carglumic acid)		

***Carbaglu (carglumic acid)* 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 the following criteria:

- ❑ Physician confirms the patient meets the drug's Health Canada approved indication for adjunctive therapy in pediatric and adult patients for the treatment of acute hyperammonemia due to deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) (57119000)

OR

- ❑ Physician confirms the patient meets the drug's Health Canada approved indication for maintenance therapy in pediatric and adult patients for chronic hyperammonemia due to the deficiency of the hepatic enzyme Naceytlglutamate synthase (NAGS) (57119000).

OR

- ❑ For the treatment of acute hyperammonemia due to Propionic Acidemia (PA) as an adjunctive therapy to other ammonia lowering therapies (T990000093); AND
  - ❑ The patient:
    - ❑ Has an established diagnosis of PA by semi-quantitative urine organic acid analysis, defined as presence of elevated Methylcitric acid and normal methylmalonic acid levels and no evidence of biotin related disorders in the organic acid analysis; AND
    - ❑ Has a plasma ammonia level ≥ 70 µmol/L; AND
    - ❑ Will use in combination with standard therapy (e.g.intravenous fluids, dextrose, intralipids, biotin, hydroxocobalamin, levocarnitine, metronidazole, and metabolic specialty formulas); AND
    - ❑ Will be treated with Carbaglu for a maximum of 7 days; AND
    - ❑ Will NOT use alternative pathway medications such as sodium benzoate and any medication with phenylacetate as an active metabolite; AND
  - ❑ The prescriber is a physician or specialist experienced in the treatment of Propionic Acidemia; AND

  Where will the treatment be administered?
    - ❑ At home; OR
    - ❑ In the physician's office; OR
    - ❑ In a private clinic; OR
    - ❑ In the hospital: ☐ In-patient ☐ Out-patient;

OR

- ❑ For the treatment of acute hyperammonemia due to Methylmalonic Acidemia (MMA) as an adjunctive therapy to other ammonia lowering therapies (T990000094); AND
  - ❑ The patient:
    - ❑ Has an established diagnosis of MMA by semi-quantitative urine organic acid analysis, defined as elevation of methylmalonic acid and no evidence of vitamin B12 dependent disorder on plasma amino acid analysis (B12 dependency is defined by documented B12 responsiveness); AND
    - ❑ Has a plasma ammonia level ≥ 70 µmol/L; AND

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Eligibility Criteria
❑ Will use in combination with standard therapy (e.g.intravenous fluids, dextrose, intralipids, biotin, hydroxocobalamin, levocarnitine, metronidazole, and metabolic specialty formulas); AND ❑ Will be treated with Carbaglu for a maximum of 7 days; AND ❑ Will NOT use alternative pathway medications such as sodium benzoate and any medication with phenylacetate as an active metabolite; AND ❑ The prescriber is a physician or specialist experienced in the treatment of Methylmalonic Acidemia; AND Where will the treatment be administered? ❑ At home; OR ❑ In the physician's office; OR ❑ In a private clinic; OR ❑ In the hospital: ☐ In-patient ☐ Out-patient; OR ❑ None of the above criteria applies Relevant additional information _____

Physician Information				
Physician's Name	Licence Number	Telephone Number	Fax Number	
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	