## PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
**For biologic response modifier: Erelzi (etanercept)**

**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<br>__ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __ | |
|---|---|---|
| Patient's Name | Patient's Date of Birth (DD/MMM/YYYY)<br>__ __ / __ __ __ / __ __ __ __ | Relationship to Employee/Insured<br>❑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 me at: | ❑ Call me (and leave a message if I'm not there) at: | ❑ Fax me at: |
|---|---|---|
| ❑ Contact my pharmacy:<br>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 |
|---|---|---|
| **Erelzi (etanercept)** | | |

**Erelzi (etanercept) 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:

For the treatment of patients with rheumatoid arthritis (RA) (69896004)

- ❑ The patient:
  - ❑ Is ≥ 18 years of age; AND
  - ❑ Has a diagnosis of moderate to severe active RA; AND
  - ❑ 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; AND
- ❑ Physician is a rheumatologist or is experienced in the management of RA,

OR

For reducing signs and symptoms of polyarticular juvenile idiopathic arthritis (JIA)

- ❑ The patient:
  - ❑ Is 4 to 17 years of age; AND
    - ❑ Weighs more than 63kgs (T990000010); AND
  - ❑ Has a diagnosis of moderate to severe active JIA, with the presence of five or more swollen joints and three or more joints with limitation of motion and pain, tenderness, or both; AND
  - ❑ Has tried and failed one or more disease-modifying anti-rheumatic drugs (DMARDs); AND
- ❑ Physician is a rheumatologist or is experienced in the management of JIA

OR

For treatment of patients with ankylosing spondylitis (AS) (9631008)

- ❑ The patient:
  - ❑ Is ≥ 18 years of age; AND
  - ❑ Has a diagnosis of moderate to severe active AS, with a Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale; AND
  - ❑ Has tried and failed a trial of at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), each administered over a minimum 2-week period at maximum recommended/tolerated doses; AND
- ❑ Physician is a rheumatologist or is experienced in the management of AS

OR

For reducing signs and symptoms, inhibiting the progression of structural damage of active arthritis, and improving physical function in adult patients with psoriatic arthritis (PsA) (156370009)

- ❑ The patient:
  - ❑ Is ≥ 18 years of age; AND
  - ❑ Has a diagnosis of PsA with at least 3 swollen and 3 tender joints; AND
  - ❑ Has tried and failed one or more disease-modifying anti-rheumatic drugs (DMARDs); AND
- ❑ Physician is a rheumatologist or is experienced in the management of PsA

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| **Eligibility Criteria** |
|---|
| OR<br><br>For the treatment of patients with chronic plaque psoriasis (PsO)<br>❑ The patient:<br>❑ Is ≥ 18 years of age (200965009); OR<br>❑ Is between the ages of 4 and 17 years; AND<br>❑ weighs 63 kg or more (T990000011); AND<br>❑ Has > 10% Body Surface Area (BSA) involvement; OR<br>❑ significant involvement of the face, hands, feet or genital regions; AND<br>❑ Has a PASI score ≥ 12; OR<br>❑ significant involvement of the face, hands, feet or genital regions; AND<br>❑ Has failed to respond, is intolerant to, or unable to access UV phototherapy; AND<br>❑ Has failed to respond, or has experienced a specific intolerance to, topical therapy and at least one systemic therapy; AND<br>❑ Prescribing physician is a dermatologist or is experienced in the management of moderate-severe plaque psoriasis<br><br>OR<br><br>❑ None of the above applies<br><br>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)<br>__ __ / __ __ __ / __ __ __ __ | |