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: (____) ________________ phone no.: (____) ________________
- contact my pharmacy at pharmacy name: ____________________________

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 (D/M/Y): ____________________________

**B. Information to be Completed by Prescribing Physician**

Drug Name: ____________________________ Strength: ____________________________ Dose: ____________________________

Iclusig will be eligible for reimbursement only if the patient satisfies one or more of the criteria 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. Please note that the drug may be eligible for reimbursement only if the patient receives it for Health Canada approved indication(s). However, 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.

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

- Physician confirms the patient meets the drug’s Health Canada approved indication for the treatment of adult patients with chronic phase (CP), accelerated phase (AP), or blast phase (BP) chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL) for whom other tyrosine kinase inhibitor (TKI) therapy is not appropriate, including CML or ALL where there is prior TKI resistance or intolerance.

OR

- None of the above criteria applies

Relevant additional information ____________________________