PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For biologic response modifier therapy: *Inflectra (infliximab)*

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
Inflectra (infliximab)		

***Inflectra (infliximab)* 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:

- ❑ Ankylosing Spondylitis (AS; 9631008):

  Initial Criteria (Approval period of 1 year):

  The patient:
  - ❑ Is ≥ 18 years of age; AND
  - ❑ Has a clinical diagnosis ankylosing spondylitis that meets the modified New York criteria for ankylosing spondylitis; AND
  - ❑ Has active ankylosing Spondylitis despite conventional therapy, meeting the following criteria:
    - ❑ A Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale for at least 4 weeks while on standard therapy; AND
    - ❑ A spinal pain score of ≥ 4 on a 0 to 10 Numerical rating scale (NRS): AND
  - ❑ Has tried and failed or is intolerant to conventional therapy including:
    - ❑ at least 2 NSAID therapies at the maximal/optimal doses for a period for at least 4 weeks each; AND
    - ❑ Disease modifying anti-rheumatic drug (DMARD) therapy, including methotrexate up to 25 mg weekly or sulfasalazine, up to 3 grams per day, if tolerated, over a period of at least 3 months (for predominantly peripheral disease); AND
  - ❑ Physician is a rheumatologist or is experienced in the management of ankylosing spondylitis

  Renewal Criteria (Approval period of 1 year):

  The patient has achieved at least 20% improvement from baseline in the Assessment of SpondyloArthritis International Society (ASAS 20), defined as:
  - ❑ Improvement of ≥ 20% AND an absolute improvement from baseline of ≥ 2 units on a scale of 0 to 10 in ≥ 3 of the 4 domains; AND
  - ❑ No worsening by > 20% and > 1 unit in the remaining fourth domain on a scale of 10

    Four Domains
    1. *Patient's global assessment of disease activity, measured on a numeric rating scale (NRS) from 0 (no activity) to 10 (severe activity);*
    2. *Total back pain defined on a NRS from 0 to 10;*
    3. *Physical function, measured by the Bath Ankylosing Spondylitis Functional Index (BASFI) which consists of 10 items assessing participants' ability to perform activities on an NRS ranging from 0 (easy) to 10 (impossible);*
    4. *Inflammation, measured by the mean of the 2 morning stiffness-related Bath AS Disease Activity Index (BASDAI) NRS scores (items 5 [level of stiffness] and 6 [duration of stiffness]) on a scale from 0 to 10.*

- ❑ Adult Crohn's Disease (including fistulizing Crohn's Disease; 34000006):

  The patient:
  - ❑ Is ≥ 18 years of age; AND
  - ❑ Has a diagnosis of moderately to severely active Crohn's Disease (CDAI score >220); AND

Eligibility Criteria

- ❑ Has Crohn's Disease involvement of the ileum and/or colon; AND
- ❑ Has failed to achieve complete remission with any of corticosteroids or immunosuppressants, OR
- ❑ Has active fistula; AND

❑ Physician is a gastroenterologist or is experienced in the management of Crohn's Disease

❑ Pediatric Crohn's Disease (NOT including fistulizing Crohn's Disease; 34000006):
The patient:
- ❑ Is ≥ 9 years of age, AND ≤ 18 years of age; AND
- ❑ Has a diagnosis of moderately to severely active Pediatric Crohn's Disease (PCDAI score >30); AND
- ❑ Has had an inadequate response to a corticosteroid and/or an immunosuppressant, OR
  - ❑ Has extensive disease defined as pan-enteric inflammation and/or deep colonic ulcers and/or perianal disease; OR
  - ❑ Is at risk for progressive, disabling disease in whom corticosteroids could exacerbate underlying conditions such as complex perianal disease, severe bone disease, mental health disorders, or linear growth delay; AND

❑ Physician is a gastroenterologist or is experienced in the management of Crohn's Disease

❑ 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

❑ 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 stable plaque psoriasis with at least one lesion ≥2 cm in diameter; 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

❑ Rheumatoid Arthritis (RA; 69896004):
The patient:
- ❑ Is ≥ 18 years of age; AND
- ❑ Has a diagnosis of moderately to severely active RA; AND
- ❑ Has had a diagnosis for ≥ 3 months; AND
- ❑ Has tried and failed a minimum 12 week trial of Methotrexate plus one other disease modifying antirheumatic drug (DMARD). Where combinations of non-biologic DMARDs are impossible (a rare situation), 3 consecutive non-biologic DMARDs would be acceptable[5]; AND
- ❑ Will be used in combination with methotrexate; AND

❑ Physician is a rheumatologist or is experienced in the management of RA

❑ Ulcerative Colitis (64766004):

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Eligibility Criteria

Initial Criteria (approval periods of 16 weeks):

The patient:

- ❑ Is ≥ 6 years of age; AND
- ❑ Has a diagnosis moderately to severely active ulcerative colitis (Mayo score 6 to 12 with endoscopic sub-score ≥2); AND
- ❑ Has had an inadequate response, loss of response, or was intolerant to conventional therapy (corticosteroid and/or aminosalicylate and/or immunosuppressant); AND

❑ Physician is a gastroenterologist or is experienced in the management of ulcerative colitis.

Renewal Criteria (approval period of 1 year):

When requesting continuation of treatment, the physician must provide information making it possible to establish the beneficial effects of the treatment, defined by:

- ❑ a decrease in the Mayo score of at least 3 points and at least 30 %, or a decrease in the partial Mayo score of at least 2 points; AND
- ❑ a Mayo rectal bleeding subscore of 0 or 1 point, or a decrease in this subscore of at least 1 point

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)
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