PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For Cancer therapy: *RYDAPT (midostaurin)*

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
RYDAPT(Midostaurin)		

***RYDAPT (MidoStaurin)* 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 ALL of the following criteria:

Acute Myeloid Leukemia:

- ❑ Physician confirms the patient meets the drug's Health Canada approved indication for the treatment of newly diagnosed acute myeloid leukemia (AML) (734522002) and patient:
  - ❑ Is 18 years of age or older; AND
  - ❑ Has had no prior anti-neoplastic therapy; AND
- ❑ Rydapt will be used in combination with standard cytarabine and daunorubicin induction chemotherapy OR standard cytarabine consolidation chemotherapy; AND
- ❑ Prescriber is an Oncologist or other specialist in the treatment of AML; AND
- ❑ Duration of therapy, including but not limited to:
  - ❑ Maximum 2 cycles of induction
  - ❑ Maximum 4 cycles of consolidation

OR

Systemic Mastocytosis (SM)/Mast cell leukemia (MCL):

- ❑ Physician confirms diagnosis of:
  - ❑ Mast Cell Leukemia (110002002); AND
    - ❑ Patient has had a bone marrow aspirate smear with ≥ 20% immature cells;

    OR
  - ❑ Aggressive systemic mastocytosis (ASM) (716655008);

    OR
  - ❑ Systemic mastocytosis with associated hematological neoplasm (SM-AHN) (397015000); AND
    - ❑ Disease is deemed not life-threatening or in acute stage; AND
- ❑ Patient:
  - ❑ Is 18 years of age or older; AND
  - ❑ Has Eastern Cooperative Oncology Group (ECOG) score of 0-3; AND
  - ❑ Does not have cardiovascular disease including congestive heart failure class III or IV according to the New York Heart Association classification, left ventricular ejection fraction (LVEF) of <50%, myocardial infarction within the previous 6 months, or poorly controlled hypertension; AND
- ❑ If SM-AHN, has not required immediate cytoreductive therapy or targeted therapy (other than RYDAPT); AND
- ❑ Prescriber is an Oncologist or other specialist in the treatment of SM or MCL

OR

- ❑ None of the above criteria applies.

Relevant additional information _____

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