PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM

Please fax form to: 1-866-840-1509

For biologic response modifier: Remicade (infliximab)

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**, **OR** mail to TELUS Health, 4141 Dixie Rd. P.O. Box 41154, Mississauga, Ont. L4W 5C9.
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 (D/M/Y) / /	Relationship to Employee/Insured (please circle) Employee Spouse Dependant

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 at pharmacy name:_____ phone no.: (_____)_____

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): _____

Please see page 2 for Prior Authorization criteria.

The most current version of this form supersedes all prior versions. The form may be modified without notice to you and we reserve the right to accept only the current version. Revised October 2014. RME-1410

B. Information to be Completed by Prescribing Physician

Drug Name:_____ Strength:_____ Dose:_____

Remicade will be eligible for reimbursement only if the patient satisfies one of the conditions listed below, AND has failed an adequate trial of the corresponding treatment of choice as indicated on the form. The treatment of choice may also be subject to prior authorization. Failure of the treatment of choice is defined as a serious side effect, contraindication, and/or an ineffective response. Coverage will then be considered only 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.**

- ❑ Ankylosing Spondylitis: Patient has tried and failed one of: Simponi, Enbrel, Humira OR Cimzia AND has tried and failed Inflectra.
- ❑ Adult Crohn's Disease: Patient (18 years or older) has tried and failed Humira.
- ❑ Pediatric Crohn's Disease: Patient (9 years or older) has tried and failed conventional treatment (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant).
- ❑ Plaque Psoriasis: Patient has tried and failed either Humira OR Stelara AND has tried and failed Inflectra.
- ❑ Psoriatic Arthritis: Patient has tried and failed one of: Simponi, Enbrel, Humira OR Cimzia AND has tried and failed Inflectra.
- ❑ Rheumatoid Arthritis: Patient has tried and failed one of: Humira, Enbrel, Simponi, Actemra, Cimzia OR Orencia SC AND has tried and failed Inflectra.
- ❑ Ulcerative Colitis: Patient has tried and failed conventional treatment (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant).

OR

- ❑ None of the above criteria applies.

Relevant additional information_____

Physician's Name	License Number	Telephone Number	Fax Number

Address	City	Province	Postal Code

Physician's Signature	Date (DD/MM/YYYY)

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