Prior Authorization Request Form: Rheumatoid Arthritis

Plan Member/Patient: Please complete pages 1 and 2 and have your physician complete pages 3 and 4. Completion of this form is not a guarantee of approval. All costs incurred to complete this form are the plan member's responsibility.

PART 1: INFORMATION TO BE COMPLETED BY THE PATIENT

Plan Member Name:	Patient Name:
Plan Member Date of Birth (YYYY/MM/DD):	Patient Date of Birth (YYYY/MM/DD):
Plan Sponsor/Employer: OpenCircle Benefit Plan	If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: □ Spouse □ Dependant
Policy/Plan Number: 55400	
Certificate Number:	

Patient Address: _____ _____ _____ _____ _____
Number Street City Province Postal Code

Patient Email: _____ Patient Phone Number: _____

PART 2: CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

As of the date hereof, I hereby authorize any person or organization who has personal health information about me, including any health care professional (which includes but is not limited to physicians, medical specialists, physiotherapists, pharmacists or any other person who has examined or treated me), health care institution, pharmacy patient support program, and other medical-related facility, Alberta Netcare, and any authorized agent of mine to release and disclose to Well and Truly RX Alberta Incorporated ("Well and Truly") the company provides prior authorization drug assessment services on behalf of the OpenCircle Benefit Plan, any personal information regarding my past medical history and current medical condition, including any relevant clinical notes (collectively, the "Personal Health Information"), which may be required to adjudicate the Request for Prior Authorization to which this Consent forms a part (the "Request").

I understand and agree that Well and Truly will keep any Personal Health Information obtained from such persons, organizations and/or agents secure and confidential and in accordance with applicable legislation and that my Personal Health Information will not be shared with any other party.

I authorize Well and Truly to collect, use and maintain my personal information, such as name, address, email address, and the Personal Health Information it deems necessary, for the purposes of adjudicating the Request or any purposes in any way ancillary thereto. I further authorize Well & Truly to contact me directly for the purposes of adjudicating the Request.

I authorize Well and Truly to collect, use and disclose my personal information in accordance with its Privacy Policy located at: https://wellandtrulyrx.ca/privacy-policy/

I hereby acknowledge and understand that:

- access to and use of my Personal Information will be limited to Well and Truly pharmacists and other Well and Truly employees in the course of their employment;
- by filling out the Request, I am not guaranteed approval for any level of coverage;
- Well and Truly has been engaged for the purpose of ensuring that criteria for the approval of claims are satisfied before approval is granted, and to ensure that the criteria for coverage are implemented consistently;
- Well and Truly has no interest, financial or otherwise, in the decision rendered in adjudicating the Request;
- Well and Truly specifically assumes no responsibility for the completeness or accuracy of any Personal Information which may be provided to Well and Truly in connection with the Request, and Well and Truly disclaims all liability for any loss or damage suffered by any person, including (without limitation) me, as a result of the processing or outcome of the Request; and
- I have no claim against Well and Truly for any loss or damage (direct, indirect, incidental, consequential or otherwise) I may suffer as a result of the handling, processing or outcome of the Request.

I understand and agree to the terms above *(If patient is <18 years old, parent/guardian to sign below).*

_____ _____ _____

Patient Full Name (please print) Patient Signature Date Signed (YYYY/MM/DD)

FOR PATIENTS OVER THE AGE OF 65 OR THOSE RESIDING IN BC, MB, AND SK:
Certain drugs require prior approval from Provincial or Pharmacare Programs before they are eligible for coverage.

ALL INITIAL AND RENEWAL SUBMISSIONS FOR PROVINCIALLY ELIGIBLE DRUGS MUST BE SUBMITTED TO THE PROVINCIAL PLAN FIRST. PLEASE ATTACH THE PROVINCIAL PLAN'S COVERAGE DECISION WITH THIS SUBMISSION.

PART 3: CO-ORDINATION OF BENEFITS

Are you currently on, or have previously been on this medication? □ Yes □ No	If yes, start date: (YYYY/MM/DD): _____ Coverage provided by: _____ ***A history of claims from pharmacy records demonstrating previous use is required***
Do you or your dependants have health benefits coverage through another health benefits company or insurance company? □ Yes □ No	If yes, name of other health benefits company/insurance company: _____ Policy/Plan Number: _____ Certificate Number: _____ Name of person holding coverage: _____

Are you currently receiving disability benefits (short-term or long-term) for the condition for which this medication has been prescribed?
□ Yes □ No

Have you applied for coverage or received any financial support for this medication:

From another insurance plan? □ Yes □ No	If yes, name of covered family member: _____ Relationship: _____ Name of insurance company: _____ Please provide details including coinsurance and any applicable maximums: _____ ***Please attach documentation of acceptance or declination.***
From a provincial program? □ Yes □ No	If yes, name of provincial program(s): _____ ***Please attach documentation of acceptance or declination.***
From a patient assistance/compassionate care program? □ Yes □ No	If yes, name of program(s): _____ Patient Assistance Program ID Number: _____ Patient Assistance Program Contact Name: _____ Patient Assistance Program Contact Information: _____

Please note, obtaining a compassionate (bridge) dose without prior authorization approval does not secure coverage.

PART 4: CURRENT/PAST PHARMACY INFORMATION

Please provide contact details of the pharmacy/pharmacies from which the patient has received medications over the last two years.

Pharmacy Name	Location (Street and City)	Phone Number

OpenCircle BENEFITS

Prior Authorization Request Form: Rheumatoid Arthritis

Prescribing Physician: Please provide information on your patient's medical condition/drug history.

PART 1: PRESCRIBER INFORMATION

Physician Name:	
Speciality:	Registration Number:
Address:	
Fax Number: _____ *(required)*	Phone Number: _____

PART 2: CLINICAL INFORMATION

Diagnosis:	Date of Initial Diagnosis (MM/YYYY):
Anticipated duration of treatment *(Maximum approval is one year before renewal is required)*:	Patient's current weight *(required)*:
Does patient have any relevant drug allergies? □ Yes □ No	Nature of allergy, if applicable: _____

Scores:

Specify date obtained: _____
DAS28: _____ PAS/PAS-II: _____ *or* HAQ Score: _____ Swollen Joint Count: _____ Tender Joint Count: _____

Presence of any of the following features:
□ Extraarticular disease (e.g., presence of rheumatoid nodules, RA vasculitis, Felty's syndrome)
□ Positive rheumatoid factor or anti-cyclic citrulinated peptide (anti-CCP) antibodies
□ Bony erosions by radiograph

Will the patient be maintained on methotrexate (MTX) in combination with the requested medication?
□ Yes □ No (If no, please specify reason): _____

PART 3: REQUIRED CONVENTIONAL THERAPIES

An adequate trial of methotrexate concurrently with one other DMARD is required before specialty therapies can be reimbursed.

Medication Name	Therapeutic Class	Dose	Start Date (MM/YYYY)	End Date (MM/YYYY)	Outcome *(Please provide details of intolerance, therapeutic failure, or contraindication)*
Methotrexate	DMARDS				
Leflunomide					
Sulfasalazine					
Hydroxyquinone					
	Other				

PART 4: PREVIOUS SPECIALTY THERAPIES

Medication Name	Therapeutic Class	Dose	Start Date (MM/YYYY)	End Date (MM/YYYY)	Outcome *(Please provide details of intolerance, therapeutic failure, or contraindication)*
	Anti-TNF				
	Anti-JAK				
	Anti-IL-6				
	Other				

PART 5: MEDICATION REQUESTED

Adalimumab:	*Infliximab:*	*Tofacitinib:*	*Tocilizumab*	*Anakinra:*
□ Humira	□ Remicade IV	□ Xeljanz	□ Actemra IV	□ Kineret
□ Hulio	□ Inflectra IV	□ Xeljanz XR	□ Actemra SC	
□ Idacio	□ Renflexis IV			*Abatacept:*
□ Amgevita	□ Avsola IV	*Baricitinib:*	*Sarilumab:*	□ Orencia IV
□ Hadlima	□ Remsima SC	□ Olumiant	□ Kevzara	□ Orencia SC
□ Hyrimoz				
	Certolizumab pegol:	*Upadacitinib:*	*Rituximab:*	*Other:*
Etanercept:	□ Cimzia	□ Rinvoq	□ Rituxan IV	_____
□ Enbrel			□ Rituxan SC	
□ Erelzi	*Golilumab:*			
□ Brenzys	□ Simponi SC			
	□ Simponi IV			

Please note that biosimilars, if available, will be preferentially approved for all new requests

Directions for Use (i.e. prescription sig):

Where will treatment be administered? □ Home □ Physician's Office □ Private Clinic □ Hospital (Inpatient) □ Hospital (Outpatient)

Name of Facility: _____ Address: _____

PART 6: RENEWAL REQUEST

Date patient started on current medication (MM/YYYY):

Patient's current weight *(required)*:

Scores:

Baseline - Specify date obtained: _____
DAS28: _____
PAS/PAS-II: _____ *or* HAQ Score: _____
Swollen Joint Count: _____ Tender Joint Count: _____

Current - Specify date obtained: _____
DAS28: _____
PAS/PAS-II: _____ *or* HAQ Score: _____
Swollen Joint Count: _____ Tender Joint Count: _____

Presence of any of the following features:
□ Extraarticular disease (e.g., presence of rheumatoid nodules, RA vasculitis, Felty's syndrome)
□ Positive rheumatoid factor or anti-cyclic citrulinated peptide (anti-CCP) antibodies
□ Bony erosions by radiograph

Concurrent DMARD therapy: OR □ Mark here if none	Medication	Dose	Dosing Regimen

ADDITIONAL INFORMATION

Please attach all relevant clinical information to support medical necessity of medication therapy requested, including any contraindications to relevant medications, as well as relevant lab tests which may support choice of medication therapy or renewal thereof.

Please be advised further information may be requested if needed to facilitate determination of coverage.

I hereby certify that the information provided is true, correct, and complete.

_____ _____

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

Please submit the completed form to OpenCircle Benefits by:

Fax: 780-455-6068 or **E-mail:** pa@opencirclebenefits.ca

Questions? Please call OpenCircle at 780-455-5845 (Edmonton) or 1-877-263-7266 (toll-free)