Please send completed forms to MHCSI:
Fax: 1-902-481-7114 **E-Mail:** professionalservices@mhcsi.ca
Mail: 201 Brownlow Avenue, Unit 20, Dartmouth, NS B3B 1W2

MHCSI PRIOR AUTHORIZATION FORM – ANKYLOSING SPONDYLITIS (INITIAL / SWITCH REQUEST)

ADALIMUMAB / ETANERCEPT / GOLIMUMAB / INFLIXIMAB / OR OTHER

Strictly confidential. This form must be completed in **FULL** and submitted to MHCSI to permit authorization for coverage of a biologic response modifier/specialty medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met and this class of medication is a benefit of your plan. Please contact MHCSI for details of the criteria for these medications. Approvals may be subject to quantity or dollar limits as per plan design.

TO BE COMPLETED BY EMPLOYEE - PATIENT INFORMATION

Member Name :		Group #	Certificate or Client ID #
Mailing Address:		City:	
Province:	Postal Code:	Phone # ( )	
Patient Name:		Date of Birth: (DD/MM/YYYY)	

Do you or any dependents have other coverage under any other plan ☐ No ☐ Yes **(If Yes, complete the following)**

Name of other Insurer:___________________________________ Member Name: ____

ID #: ____ Policy #: ____

Is this drug covered by coordinating plan? ☐ No ☐ Yes

Are you enrolled in a manufacturer patient assistance program? ☐ No ☐ Yes (program name)____

*** IMPORTANT, this section of form must be completed in order to avoid processing delays***

You are enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs, Sobeys Pharmacy; Sobeys Pharmacy by Mail, Safeway Pharmacy, FreshCO Pharmacy, Thrifty Foods Pharmacy, Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island.

☐ **My PPN pharmacy location is:** ____

☐ I choose not to use a PPN pharmacy. Reason: ____

Note: Access to some covered specialty medications may be limited to select pharmacy providers.

I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.

Signature (patient 14 yr. and older/parent/legal guardian) **X**	**Date:** (DD/MM/YYYY)

TO BE COMPLETED BY RHEUMATOLOGIST – MEDICATION/DIAGNOSTIC INFORMATION FOR INITIAL COVERAGE

Requested Dose and Interval __________ mg, every ____________	Patient's Body Weight kg	(required for : Infliximab)	Year of Diagnosis of Ankylosing Spondylitis (YYYY):

Adalimumab
- ☐ Humira 40mg PFS DIN 02258595
- ☐ Humira 40mg Auto Injector Pen DIN 02258595

Etanercept
- ☐ Enbrel 25mg vial DIN 02242903
- ☐ Enbrel 50mg PFS DIN 02274728
- ☐ Enbrel 50mg PFS Sureclick DIN 02274728

Golimumab
- ☐ Simponi 50mg PFS DIN 02324776
- ☐ Simponi 50mg Auto Inject DIN 02324784
- ☐ Simponi 100mg Auto Inject DIN 02413183
- ☐ Simponi 100mg PFS DIN 02413175
- ☐ Simponi 50mg IV Vial DIN 02417472

Infliximab
- ☐ Remicade 100mg Vial DIN 02244016
- ☐ Inflectra 100mg Vial DIN 02419475

Other (please provide drug name, DIN and requested dose):

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TO BE COMPLETED BY RHEUMATOLOGIST – CURRENT CLINICAL INFORMATION

ESR or CRP	Morning Stiffness (Minutes):	**Physician Overall Assessment of Inflammation:** (scale of 0-10), 0 = none, 10 = severe active disease	
CURRENT MEDICATIONS *as pertains to condition*	**DOSE**	**ROUTE**	**FREQUENCY**

☐ **BASDAI score** currently: _______________

☐ **Axial Disease** symptoms (details): ____

☐ **Peripheral Disease** symptoms (details): ____

MEDICATIONS TRIED (NSAID's & DMARDS)	DOSE/FREQUENCY	DURATION	RESPONSE / ADVERSE EVENT

Indicate reason(s) / contraindications if NSAIDs and or DMARDS have not been tried: ___________________________________
____

TO BE COMPLETED BY RHEUMATOLOGIST – PRIOR BIOLOGIC USAGE IF MEDICATION SWITCH

NAME, DOSE & FREQUENCY	DURATION, PLEASE SPECIFY DATES	FAILURE TYPE 1*	TYPE II*	SIDE EFFECT(S) OR CONTRAINDICATION(S) - SPECIFY
		☐	☐	
		☐	☐	
		☐	☐	

*Never achieving a 20% improvement **At least 20% improvement in first 12 weeks of a TNF inhibitor (24 weeks for abatacept and rituximab) but loss of benefit

Prescribing Physician: Please note this patient is enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs; Sobeys Pharmacy; Sobeys Pharmacy by Mail; Safeway Pharmacy; FreshCO Pharmacy; Thrifty Foods Pharmacy Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island.

PRESCRIBING RHEUMATOLOGIST	DISPENSING PHARMACIST
Name and Mailing Address:	Name, Store & Contact Information:
Phone: _________________ Fax:_____________________	Phone: _________________ Fax:_____________________

MHCSI OFFICE USE

☐ Approved Extension Possible ☐ Yes ☐ No ☐ Declined DECLINE CODE:_______		**Notes:**
Date:	Ph.C.:	
Approved Date Range:		
Quantity	Processing Number:	
PPN Only: ☐ Yes ☐ No PPN Dispensing Pharmacy Called: ☐ Yes ☐ No		