AGA BENEFIT SOLUTIONS

INFORMATION DRUG REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

USTEKINUMAB (Finlius, Jamteki, Stelara, Steqeyma, Wezlana)

SECTION 1 – INFORMATION ON THE MEMBER

Member name:	Group number:	Certificate number:
Address (No. / Street / Apt.):		
City :	Province :	Postal Code :
Phone number :	E-mail address :	
Employer name / Policy holder: :	Group / Division number:	

SECTION 2 – INFORMATION ON THE PATIENT

Patient name:	
Patient Date of Birth (YYYY/MM/DD):	Relationship to member:

Have you applied for coverage with a provincial program? ☐ YES ☐ NO

Has your application for coverage with the provincial program for this drug or supply been approved? ☐ YES ☐ NO

If you have applied for coverage with a provincial program, please provide us with a copy of the refusal or acceptance letter.

Are you enrolled in a drug manufacturer's patient assistance program? ☐ YES ☐ NO

If yes, please provide your patient assistance program identification number: _____

SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION

I authorize any health professional (doctor, pharmacist, dentist), any person (service provider), any other insurance company, any public or private health institution, any government agency in relation to health or social services, to disclose and exchange requested information by the insurer or AGA Benefits Solutions, necessary for the evaluation of my request for prior authorization for that drug.

Patient signature:	Date:
Signature of the subscriber when patient is a minor:	Date:

SECTION 4 - DRUG COVERED BY THE APPLICATION

Drug Name:		
Dosage:		
Pharmaceutical Form:		Content / Strength:
Anticipated duration of treatment:	From (YYYY/MM/DD) :	To (YYYY/MM/DD) :
Diagnosis:		Initial date of diagnosis (YYYY-MM-DD):

Medication will be administered at the following location:

☐ Home ☐ Health and social service center ☐ Long-term care center ☐ Private clinic

☐ Hospital - internal patient ☐ Hospital - external patient ☐ Elsewhere. Specify : _____

If the treatment is not administered at home, please provide the following information:

Name of the location where the drug will be administered:		Telephone:	
Address (No. / Street / Apt.):	City :	Province:	Postal Code :

SECTION 5 - TYPE OF APPLICATION

☐ Initial request	☐ Continued treatment	☐ Modification of treatment

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SECTION 6- SUMMARY OF PREVIOUS TRIALS OR CONTRAINDICATIONS

Please provide a list of medicines and/or treatments used to date to control this condition:

Name of drug/treatment currently or previously prescribed	Content - strength / Dosage	Trial Period From (YYYY-MM-DD)	Trial Period To (YYYY-MM-DD)	Reason for Discontinuation
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:

SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

BIOSIMILAR DRUGS

Requests for treatment with **STELARA** will no be considered effective on the transition date set for your residential province, since biosimilar drugs are available on the market. If the patient's situation doesn't allow them to transition to a biosimilar version of **STELARA**, indicate the reason below :

☐ Pregnant patient - Due date (YYYY/MM/DD) : _____

☐ Pediatric patient

☐ Patient for whom treatment with at least 2 other biologic drugs had failed

Please indicate the biologic drugs that were tried : _____

☐ Other - Please provide sufficiently documented medical justification.

DIAGNOSIS

☐ Psoriatic arthritis ☐ Crohn's disease

☐ Rheumatoid polyarthritis ☐ Plaque Psoriasis

☐ Ulcerative colitis ☐ Other. Specify : _____

PSORIATIC ARTHRITIS OR RHEUMATOID POLYARTHRITIS

☐ Psoriatic arthritis (rheumatoid form) ☐ Psoriatic arthritis (other than the rheumatoid form) ☐ Rheumatoid polyarthritis

☐ Peripheral psoriatic arthritis ☐ Axial psoriatic arthritis

Please provide the following pre-treatment information as well as the date on which they were obtained :

HAQ Initail assessment : _____ Date (YYYY/MM/DD) : _____

C-reactive protein value Initail assessment : _____ mg/L Date (YYYY/MM/DD) : _____

BASDAI Initail assessment : _____ Date (YYYY/MM/DD) : _____

Sedimentation rate Initail assessment : _____ mm/h Date (YYYY/MM/DD) : _____

Number of joints with active synovitis : _____

Presence of a positive rheumatoid factor? ☐ Yes ☐ No

Presence of radiological erosions? ☐ Yes ☐ No

ULCERATIVE COLITIS

Please specify the form of the condition: ☐ Moderate ☐ Severe

Please provide the following pre-treatment information as well as the date on which they were obtained :

MAYO Initail assessment : _____ Date (YYYY/MM/DD) : _____

Mayo endoscopic subscore Initail assessment : _____ Date (YYYY/MM/DD) : _____

Rectal bleeding subscore Initail assessment : _____ Date (YYYY/MM/DD) : _____

Partial Mayo score Initail assessment : _____ Date (YYYY/MM/DD) : _____

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SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

ULCERATIVE COLITIS

Was the drug started at hospital? ☐ Yes ☐ No

If yes, specify the following information: Admission date (YYYY/MM/DD) : _____ Discharge date (YYYY/MM/DD) : _____

Will the drug be taken in combination with other treatment for ulcerative colitis? ☐ Yes ☐ No

If yes, specify the treatment(s) : _____

Did the patient require hospitalization for severe symptoms? ☐ Yes ☐ No

If yes, specify the symptoms : _____

Was the patient stabilized after a treatment with prednisone, but the dose cannot be tapered despite the use of immunosuppressants?

☐ Yes ☐ No

CROHN'S DISEASE

Please specify the form of the condition: ☐ Moderate ☐ Severe

Fistulizing disease : ☐ Yes ☐ No

Does the patient have actively draining perianal or enterocutaneous fistula(e) that have recurred or persist despite a course of antibiotic therapy and immunosuppressive therapy?

☐ Yes ☐ No

If yes, specify the antibiotic and immunosuppressive therapies used : _____

_____

Did the patient require hospitalization for severe symptoms? ☐ Yes ☐ No

If yes, specify the symptoms : _____

Presence of the following features for high-risk (if applicable):

☐ Elevated C-reactive protein and/or fecal calprotectin levels ☐ Deep ulcers on colonoscopy

☐ Long segments of small and/or large bowel involvement ☐ Extra-intestinal manifestations

☐ History of bowel resections ☐ Perianal disease

Please provide the following pre-treatment information as well as the date on which they were obtained :

CDAI Initail assessment : _____ Date (YYYY/MM/DD) : _____

HBI Initail assessment : _____ Date (YYYY/MM/DD) : _____

Was the drug started at hospital? ☐ Yes ☐ No

If yes, specify the following information: Admission date (YYYY/MM/DD) : _____ Discharge date (YYYY/MM/DD) : _____

Site of disease and complications: _____

Did patient receive a trial of IV steroids for a minimum of 3 days while hospitalized? ☐ Yes ☐ No

PLAQUE PSORIASIS

Please provide the following pre-treatment information as well as the date on which they were obtained :

DLQI Initail assessment : _____ Date (YYYY/MM/DD) : _____

PASI Initail assessment : _____ Date (YYYY/MM/DD) : _____

% BSA involved (body surface area) Initail assessment : _____ Date (YYYY/MM/DD) : _____

Presence of large plaques? ☐ Yes ☐ No

Specify the body areas that are involved: ☐ Face ☐ Hand ☐ Feet ☐ Genital region ☐ Other. Specify : _____

Was there a failure to phototherapy treatment? ☐ Yes ☐ No

Number of sessions : _____ Duration of treatment (months) : _____

Indication shy the phototherapy treatment had to be stopped : ☐ Contraindication ☐ Not accessible

☐ Other. Specify : _____

Will the treatment be administered in combination with a standard systemic treatment or biologic treatment? ☐ Yes ☐ No

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SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

PSORIATIC ARTHRITIS OR RHEUMATOID POLYARTHRITIS

Number of joints with active synovitis in the initail assessment : _____

Number of joints with active synovitis in the most recent assessment : _____ Date (YYYY/MM/DD) : _____

Is the patient back to work? ☐ Yes ☐ No

If yes, specify the return-to-work date (YYYY/MM/DD) : _____

ULCERATIVE COLITIS

Please provide the **recent** following information as well as the date on which they were obtained :

MAYO	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
Mayo endoscopic subscore	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
Rectal bleeding subscore	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
Partial Mayo score	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____

Has there been improvement in stool frequency or rectal bleeding? ☐ Yes ☐ No

CROHN'S DISEASE

Please provide the **recent** following information as well as the date on which they were obtained :

CDAI	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
HBI	Initail assessment : _____ mg/L	Recent assessment : _____	Date (YYYY/MM/DD) : _____

Beneficial effects obtained : _____

_____

PLAQUE PSORIASIS

Please provide the **recent** following information as well as the date on which they were obtained :

PASI	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
DLQI	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
% BSA involved (body surface area)	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____

Significant improvement of the lesions on the body : ☐ Yes ☐ No

SECTION 9– ADDITIONAL INFORMATION (optional)

SECTION 10 – SIGNATURE OF AUTHORIZED PRESCRIBER

Print name of authorized prescriber:	Specialty of the physician:	
Signature of authorized prescriber:	License Number:	Date :

SECTION 11 - IMPORTANT PATIENT INFORMATION

Fees may be charged to complete this form, it is the patient's responsibility to pay them.
Ensure all required sections of the form have been completed and signed before returning it.
Attach any additional documents required on this form.
Your request may be delayed if we do not have all the necessary information.
The drug will be eligible only if it meets the criteria established by the insurer.

HOW TO RETURN THE FORM

By email : **exceptions@aga.ca** By fax: (514) 935-1147	By mail : AGA Benefit Solutions 3500 de Maisonneuve Blvd. W, suite 2200 Westmount (QC) H3Z 3C1