Sun Life

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Prior Authorization Request

DUPIXENT (dupilumab)

Instructions

Please complete Part A and have your physician complete Part B. This form may not apply to your specific plan. Before completing the Prior Authorization form, check that this medication is on your plan's drug coverage list. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. If you've already purchased the drug, please attach your original receipts along with a regular extended health care claim form.

Part A – Patient

Patient Information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Please check any box that applies to the patient:

☐ The patient is an over-age student dependent (i.e. attending University or College full-time). A copy of the enrolment document from the educational institution confirming full-time status is enclosed.

☐ The patient is a spouse or a dependent over age 18. The patient has signed the authorization section below that allows Sun Life to obtain the additional medical information pertaining to this request.

Coordination of benefits

Provincial Coverage	You applied for a drug that may be covered under a provincial plan. To find out if you qualify for coverage, speak to your doctor and apply to the province. Show the provincial response letter to your pharmacist when you receive it.
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

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Authorization

The answers on this form are true. I allow Sun Life to collect, use and disclose my personal information for three reasons. These reasons are plan administration, underwriting coverage and assessing claims. Sun Life may share (meaning collect and disclose) information with healthcare providers, hospitals, clinics, pharmacies, government programs, patient assistance programs, and any other organization with relevant information about me. Sun Life may also share information with insurers or reinsurers, and agents and service providers of Sun Life and the above parties. Sun Life will share my information only when necessary. My consent applies while this plan is in effect.
I agree that a photocopy or electronic version of this authorization is as valid as the original.

Plan Member Signature _____ Date _____

Patient Signature (if over 18 years of age) _____ Date _____

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

DUPIXENT (dupilumab)	☐ New request	☐ Renewal request*		
DIN(s)	Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Private Clinic ☐ Private Clinic (within Hospital - no public or government funding)

☐ Hospital (inpatient) ☐ Hospital (outpatient)

Name of the hospital or private clinic:

Address:

City:	Province:	Postal code:

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Atopic Dermatitis

INITIAL

- ☐ For the treatment of moderate-to-severe atopic dermatitis (AD), AND
- ☐ The patient is 6 months of age or older, AND
- ☐ The patient has an affected body surface area (BSA) of 10% or greater, or there is involvement of the patient's face, hands, feet or genital region, AND
- ☐ The patient has an Investigator's Global Assessment (IGA) score of 3 or greater, AND
- ☐ The patient has an Eczema Area and Severity Index (EASI) score of 16 or greater, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 topical agents that are high potency corticosteroids or calcineurin inhibitors, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to a systemic treatment, if an adult

RENEWAL

- ☐ The patient has demonstrated improvement defined as 75% or greater improvement from baseline in EASI score

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Asthma – Type 2/Eosinophilic Phenotype

INITIAL

- ☐ For the add-on maintenance treatment of severe asthma with a type 2/eosinophilic phenotype, AND
- ☐ The patient is 6 years of age or older, AND
- ☐ The patient is inadequately controlled with high-dose inhaled corticosteroids, and 1 or more additional asthma controller(s) (e.g. long-acting beta agonists), AND
- ☐ The patient has a blood eosinophil count of 150 cells/mm^3 or greater, AND
- ☐ The patient has a forced expiratory volume in 1 second (FEV1) less than 80% of predicted normal for an adult, or 90% or less of predicted normal for an adolescent

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in the number of asthma exacerbations, a decrease in administration of rescue medication)

Asthma – Corticosteroid-Dependent

INITIAL

- ☐ For the add-on maintenance treatment of severe asthma with oral corticosteroid-dependence, AND
- ☐ The patient is 6 years of age or older, AND
- ☐ The patient has been treated with an oral corticosteroid daily for at least 6 months, AND
- ☐ The patient is inadequately controlled with high-dose inhaled corticosteroids, and 1 or more additional asthma controller(s) (e.g. long-acting beta agonists)

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in the number of asthma exacerbations, a decrease in daily oral corticosteroid use, a decrease in administration of rescue medication)

Chronic Rhinosinusitis with Nasal Polyposis

INITIAL

- ☐ For the treatment of severe chronic rhinosinusitis with nasal polyposis (CRSwNP) in an adult, AND
- ☐ The patient has a nasal polyp score (NPS) of 5 or greater, AND
- ☐ The patient has a nasal congestion (NC) score of 2 or greater, AND
- ☐ The patient has been treated with sinus surgery, OR
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 nasal corticosteroids, and to an oral corticosteroid

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in nasal polyp size, a reduction in nasal congestion, a reduced need for systemic corticosteroids)

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Eosinophilic Esophagitis

INITIAL

- ☐ For the treatment of eosinophilic esophagitis (EoE), AND
- ☐ The patient is 12 years of age or older, AND
- ☐ The patient weighs 40kg or more, AND
- ☐ The patient has a diagnosis of eosinophilic esophagitis as confirmed by an endoscopic biopsy demonstrating 15 or greater intraepithelial eosinophils per high-power field (eos/hpf), AND
- ☐ The patient has a Dysphagia Symptom Questionnaire (DSQ) score of 10 or greater, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to either an 8-week course of high-dose proton pump inhibitor (PPI) or a topical glucocorticoid

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduced intraepithelial eosinophil count, a decrease in DSQ score)

Prurigo Nodularis

- ☐ For the treatment of moderate to severe prurigo nodularis (PN) in an adult, AND
- ☐ The patient has an average worst itch score of 7 or greater on the Worst-Itch Numeric Rating Scale (WI-NRS) ranged from 0 to 10, AND
- ☐ The patient has 20 or greater nodular lesions, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to medium to ultra-high potency topical corticosteroids

OR

- ☐ None of the above criteria applies.

Relevant additional information:

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SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

SECTION 4 – RESPECTING YOUR PRIVACY

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at www.sunlife.ca/privacy or call us for a copy.

Questions? Please visit *www.sunlife.ca* or call toll-free 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

SECTION 5 – CONTACT US

You can submit **all** pages of this form through the mysunlife mobile app or mysunlife.ca. Please use 'prior auth' as the reference number.

OR

Please fax or mail the completed form to Sun Life Assurance Company of Canada ®

FAX: 1-855-342-9915

Mail:

Sun Life Assurance Company of Canada
Attention: Claims Dept.
PO Box 11658 STN CV
Montreal, QC H3C 6C1

Sun Life Assurance Company of Canada
Attention: Claims Dept.
PO Box 2010 STN Waterloo
Waterloo, ON N2J 0A6