Sun Life

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Prior Authorization Request

HUMIRA, ABRILADA, AMGEVITA, HADLIMA, HULIO, HYRIMOZ, IDACIO, SIMLANDI, YUFLYMA (adalimumab)

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

☐ HUMIRA	☐ ABRILADA	☐ AMGEVITA	☐ New request
☐ HADLIMA	☐ HULIO	☐ HYRIMOZ	☐ Renewal request*
☐ IDACIO	☐ SIMLANDI	☐ YUFLYMA	

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:**

Rheumatoid Arthritis

- ☐ For the treatment of moderately to severely active rheumatoid arthritis in an adult, AND
- ☐ The patient has had an inadequate response to a minimum 12-week trial of methotrexate in combination with another disease modifying anti-rheumatic drug (DMARD), OR
- ☐ Where combinations of non-biologic DMARDs are impossible, the patient has tried 3 consecutive non-biologic DMARDs, unless patient has a documented intolerance to DMARDs

Polyarticular Juvenile Idiopathic Arthritis

- ☐ For the treatment of moderately to severely active polyarticular juvenile idiopathic arthritis, AND
- ☐ The patient is 2 years of age or older, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to 1 or more disease modifying anti-rheumatic drugs (DMARDs), or to another biologic response modifier

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Ankylosing Spondylitis

- ☐ For the treatment of ankylosing spondylitis in an adult, AND
- ☐ The patient has a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score of 4 or greater on a 10-point scale, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs) for a minimum of 2 weeks each, or to at least 2 disease modifying anti-rheumatic drugs (DMARDs) for a minimum of 3 months, or to another biologic response modifier

Psoriatic Arthritis

- ☐ For the treatment of psoriatic arthritis in an adult, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 disease modifying anti-rheumatic drugs (DMARDs), or to another biologic response modifier

Hidradenitis Suppurativa

- ☐ For the treatment of hidradenitis suppurativa, AND
- ☐ The patient is 12 years of age or older, AND
- ☐ The patient weighs 30kg or more, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to systemic antibiotics

Crohn's Disease

- ☐ For the treatment of moderately to severely active Crohn's disease, AND
- ☐ The patient is 13 years of age or older, AND
- ☐ The patient weighs 40kg or more, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to either aminosalicylates, immunomodulators, corticosteroids, or to another biologic response modifier

Plaque Psoriasis

- ☐ For the treatment of moderate to severe plaque psoriasis in an adult, 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 a Psoriasis Area and Severity Index (PASI) score of 10 or greater, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to phototherapy, unless it is inaccessible, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to conventional systemic therapy, or to another biologic response modifier

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Ulcerative Colitis

- ☐ For the treatment of moderately to severely active ulcerative colitis, AND
- ☐ The patient is 5 years of age or older, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to corticosteroids and to either aminosalicylates or immunomodulators

Adult Uveitis

- ☐ For the treatment of non-infectious uveitis (intermediate, posterior or panuveitis) in an adult, AND
- ☐ The patient has active disease despite at least 2 weeks of therapy with oral corticosteroids, OR
- ☐ The patient is dependent on an oral corticosteroid

Pediatric Uveitis

- ☐ For the treatment of non-infectious anterior uveitis, AND
- ☐ The patient is 2 years of age or older, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 12 weeks of methotrexate

OR

- ☐ None of the above criteria applies.

Relevant additional information:

2. Additional criteria for HUMIRA requests

- ☐ The patient is intolerant to, or had a confirmed adverse event with a biosimilar

SECTION 3 – PRESCRIBER INFORMATION

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

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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