Sun Life

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Prior Authorization Request

REPATHA (evolocumab)

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

REPATHA (evolocumab) ☐ 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:**

Atherosclerotic Cardiovascular Disease

INITIAL

- ☐ For the treatment of clinical atherosclerotic cardiovascular disease (ASCVD) in an adult defined by one of the following: ischemic heart disease (angina, history of heart attack), cerebrovascular disease (stroke), and/or peripheral vascular disease/peripheral arterial disease, AND
- ☐ The patient is taking one moderate-to-high intensity statin or has a documented intolerance to at least 2 statins, AND
- ☐ The patient has had an inadequate response or has a documented intolerance or contraindication to ezetimibe, AND
- ☐ The patient's LDL-C level is 1.8 mmol/L or greater, or non-HDL-C level is 2.4 mmol/L or greater, or Apo-B level is 0.7 g/L or greater, despite taking a maximally tolerated statin dose

RENEWAL

- ☐ The patient has demonstrated LDL-C, non-HDL-C, or Apo-B reduction to target

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Heterozygous Familial Hypercholesterolemia

INITIAL

- ☐ For the treatment of heterozygous familial hypercholesterolemia (HeFH) in patients unable to reach target LDL-C levels, AND
- ☐ The patient is 10 years of age or older, AND
- ☐ The patient is currently receiving a maximally-tolerated dose of statin therapy, OR
- ☐ The patient has a documented intolerance or contraindication to at least two different statins, AND
- ☐ The patient has had an inadequate response or has a documented intolerance or contraindication to ezetimibe, AND
- ☐ The patient's LDL-C level is 2 mmol/L or greater despite current therapy, OR
- ☐ The patient has not achieved a 50% reduction in LDL-C from pre-treatment levels despite current therapy, OR
- ☐ The patient's non-HDL-C level is 2.4 mmol/L or greater, or Apo-B level is 0.7 g/L or greater despite current therapy

RENEWAL

- ☐ The patient has demonstrated LDL-C, non-HDL-C, or Apo-B reduction to target

Homozygous Familial Hypercholesterolemia

INITIAL

- ☐ For the treatment of homozygous familial hypercholesterolemia (HoFH) defined by a family history of FH in both parents and/or premature atherosclerotic cardiovascular disease, AND
- ☐ The patient is 10 years of age or older, AND
- ☐ The patient has pre-treatment LDL-C levels greater than 12 mmol/L, AND
- ☐ The patient had tendon xanthomas before the age of 10, AND
- ☐ The patient is taking one high-intensity statin therapy, OR
- ☐ The patient has a documented intolerance or contraindication to at least two different statins, AND
- ☐ The patient has had an inadequate response or has a documented intolerance or contraindication to ezetimibe, AND
- ☐ The patient's LDL-C level is 2 mmol/L or greater despite current therapy, OR
- ☐ The patient has not achieved a 50% reduction in LDL-C from pre-treatment level despite current therapy

RENEWAL

- ☐ The patient has demonstrated LDL-C reduction to target

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OR

☐ None of the above criteria applies.

Relevant additional information:

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

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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