Sun Life

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Prior Authorization Request

XOLAIR, OMLYCLO (omalizumab)

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

☐ XOLAIR ☐ OMLYCLO				☐ 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:**

Allergic Asthma

- ☐ For the treatment of moderate to severe persistent allergic asthma, AND
- ☐ The patient is 6 years of age or older, AND
- ☐ The patient has a positive skin test or in vitro reactivity to perennial aeroallergen, AND
- ☐ The patient's symptoms are inadequately controlled with inhaled corticosteroids, AND
- ☐ The patient has a total IgE level between 30 IU/mL and 700 IU/mL (72 ng/mL to 1680 ng/mL) at baseline if 12 years of age or older, OR
- ☐ The patient has a total IgE level between 30 IU/mL and 1300 IU/mL (72 ng/mL to 3120 ng/mL) at baseline if between 6 to 11 years of age

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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 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)

Chronic Idiopathic Urticaria

INITIAL – *6 month approval*

- ☐ For the treatment of chronic idiopathic urticaria (CIU), AND
- ☐ The patient is 12 years of age or older, AND
- ☐ The patient remains symptomatic despite H1 antihistamine treatment at a maximum-tolerated dose

RENEWAL – *6 month approval*

- ☐ The patient has demonstrated a complete response lasting less than 12 weeks (urticaria activity score [UAS7] of 6 or less), OR
- ☐ The patient has demonstrated a partial response (UAS7 score reduction by at least 9.5 points from baseline value and the UAS7 remains greater than 6), OR
- ☐ The patient has demonstrated relapse after a complete response lasting 12 weeks or more, after which treatment has stopped and UAS7 score is 16 or greater

OR

- ☐ None of the above criteria applies.

Relevant additional information:

2. Additional criteria for XOLAIR requests

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

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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