# Public Service Health Care Plan
## Drug Prior Authorization Form
## Ebglyss (lebrikizumab)

**PROTECTED "B" WHEN COMPLETED**

## PART 1 – Instructions

Please use this form to submit your application for Ebglyss to Canada Life.

1. Complete parts 2 to 7 in full and have your attending physician or nurse practitioner complete parts 8 to 9.
2. Please apply for coverage through the appropriate provincial/territorial health program before submitting this application to Canada Life (if applicable).
3. Send to Canada Life. See part 10.

Please note that physician's fees for providing medical information are not covered under the Public Service Health Care Plan (PSHCP).

All forms under the Public Service Health Care Plan (PSHCP) must be submitted through the plan member. We may disclose personal information about claims with your employer, your service provider, and/or a person acting on your behalf when necessary to confirm eligibility and to mutually manage your assessment.

## PART 2 – Plan member information - You must complete this section fully. If you are unsure of your plan or certificate number, please see your Public Service Health Care Plan (PSHCP) benefit card, the Canada Life PSHCP Member Service website or Part 10 for our contact information.

Plan name: **Public Service Health Care Plan**

Plan number

Plan member certificate number

**Plan member name**

First name

Last name

**Plan member address**

Number and street

City or town

Province/Territory/State

Postal/Zip Code

Country

**Date of birth** Day Month Year

## PART 3 – Patient information

| Patient name | | Patient's relationship to plan member | | | Patient's date of birth | | | If dependant child is between 21 and 25 years old, are they a full-time student? | |
|---|---|---|---|---|---|---|---|---|---|
| First name | Last name | Self | Spouse or common-law partner | Dependant child | Day | Month | Year | Yes | No |
| | | ☐ | ☐ | ☐ | | | | ☐ | ☐ |

1. Is the patient currently on or previously been on this drug? ☐ Yes ☐ No

   If "Yes", please answer the questions below.

   a. Indicate the date you started this medication. Day Month Year

   b. Coverage provided by: _____

   (if coverage was not provided by Canada Life, please provide a pharmacy print-out showing purchase of this drug)

2. Has the patient enrolled in the Patient Support Program for this drug? ☐ Yes ☐ No

   If "Yes", please provide the following information: Patient Support Program ID number: _____

   Patient Support Program contact name: _____ Phone number: _____

## PART 4 – Coordination of benefits - Complete this section to indicate whether the patient has benefit coverage under any other plan.

1. Does the patient have prescription drug coverage under any other benefit plan? ☐ Yes ☐ No

   If "Yes", please answer the questions below.

2. Name of the insurance company? _____

3. Is the other plan with Canada Life? ☐ Yes ☐ No

   If "Yes", please provide: Canada Life plan number _____ Certificate number _____

   Name of plan member _____ Relationship to patient _____

   Other insurance plan member's signature of authorization: X _____

Provide details and attach documentation of your other insurance company's acceptance or denial of this drug:

_____

## PART 5 – Provincial or territorial coverage

1. Does the patient have coverage under a provincial or territorial program or from any other source? ☐ Yes ☐ No

   If "Yes", name of program or other source: _____

Provide details and attach documentation of the province or territory's acceptance or denial of this drug:

_____

## PART 6 – Privacy

*Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to canadalife.com or write to Canada Life's Chief Compliance Officer.*

*Please refer to the PSHCP Privacy Statement (canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html) for further information on how your privacy is protected. Where there is a difference between the Privacy Act (///laws-lois.justice.gc.ca/eng/acts/P-21/) and the PSHCP Privacy Statement and Canada Life's Privacy guidelines, Canada Life will apply the most stringent requirements.*

## PART 7 – Confirmation, authorization and signature

*I authorize Canada Life, any healthcare or dentalcare provider, my plan sponsor, the Federal PSHCP Administration Authority, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.*

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

In accordance with the Positive Enrolment Authorization and Declaration (welcome.canadalife.com/pshcp/review-authorizations-and-declarations.html) accepted during the completion of Positive Enrolment (refer to your Positive Enrolment Record if you completed Positive Enrolment by paper), I agree to the collection, use and disclosure of personal information as set out in the Privacy section, Canada Life's Privacy guidelines and the PSHCP Privacy Statement.

**I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.**

**Plan member signature X** _____ **Date** Day | Month | Year

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## PART 8 – Patient medical information - To be completed by the attending physician or nurse practitioner.

**Attach extra information if necessary. GENETIC TEST RESULTS ARE NOT REQUIRED.**

1. Prescribed dosage and regimen:
   - ☐ 500mg subcutaneously weeks 0 and 2, then 250mg every two weeks until week 16, then 250mg every four weeks
   - ☐ Other (please specify): _____
     Provide rationale: _____
2. Health Canada indication (include date of initial diagnosis): Month Year
   - ☐ Atopic Dermatitis
     Complete questions 1-6 and Patient medical information.
   - ☐ Other (approved by Health Canada): _____
     Complete questions 1-6 and Other condition (Health Canada approved).
3. What is the anticipated duration of treatment with this drug? _____
4. Where will treatment be administered? ☐ Home ☐ Physician's office ☐ Private clinic ☐ Hospital in-patient ☐ Hospital out-patient
5. Please provide medical rationale why this drug has been prescribed instead of an alternate drug with an approved indication for this condition. Genetic test results are not required.

   _____

   _____
6. Drug and treatment history – **must be completed for every request.**

| Prescription drug(s) and treatment(s) past and present | Dosing regimen | Start date (mmm-dd-yyyy) | End date (mmm-dd-yyyy) | Clinical results/outcome |
|---|---|---|---|---|
| | | | | ☐ Failure ☐ Intolerance ☐ Other<br>Clinical details: |
| | | | | ☐ Failure ☐ Intolerance ☐ Other<br>Clinical details: |

## Atopic Dermatitis

Please indicate atopic dermatitis severity: ☐ Mild ☐ Moderate ☐ Severe

Please indicate the percentage affected body surface area (BSA): _____

Please indicate the affected area(s): _____

Has UV therapy been trialed for this patient? ☐ Yes ☐ No

If yes, please indicate start and stop dates (DD/MM/YYYY) along with reason(s) for discontinuation:

_____

Please submit at least one of the following at baseline and for renewal:

EASI score prior to starting Ebglyss: _____ Date determined Day Month Year

Current EASI score at Ebglyss renewal: _____ Date determined Day Month Year

IGA score prior to starting Ebglyss: _____ Date determined Day Month Year

Current IGA score at Ebglyss renewal: _____ Date determined Day Month Year

Will Ebglyss be used in combination with other biologic immunomodulators or JAK inhibitors for the treatment of atopic dermatitis (e.g. Adtralza, Cibinqo, Dupixent or Rinvoq)? ☐ Yes ☐ No

**Ensure the Drug and Treatment History chart is completed.**

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## PART 8 – Patient medical information, continued - To be completed by the attending physician or nurse practitioner.

### Other condition (Health Canada approved)

Please provide any relevant information related to the disease and attach supporting documentation.

## PART 9 – Attending physician's or nurse practitioner's information, confirmation, and signature

**I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.**

**Physician or nurse practitioner's name**

Name and designation

Specialty

Registration number

**Physician or nurse practitioner's address**

Number and street

City or town

Province/Territory/State

Postal/Zip Code

Telephone number (including area code)

Fax number (including area code)

**Signature X** _____

**Date** Day Month Year

## PART 10 – Submitting your application

Please send the completed form to:

**MAIL**

Drug Claims Management
The Canada Life Assurance Company
PO Box 6000 Winnipeg MB R3C 3A5

**FAX**

Drug Claims Management
1-204-946-7664

**EMAIL**

cldrug.services@canadalife.com

**Questions?**

Call toll free 1-855-415-4414
Monday to Friday from 8 am to 5 pm, your local time or sign in to your account on the Canada Life PSHCP Member Services website at canadalife.com/pshcp and go to the Contact Us page.

**Deaf or hard of hearing and require access to a telecommunications relay service?**
Please contact us:
TTY to Voice: 711 • Voice to TTY: 1-800-855-0511

Clear