Public Service Health Care Plan
Drug Prior Authorization Form
eltrombopag olamine

PROTECTED "B" WHEN COMPLETED

PART 1 – Instructions

Please use this form to submit your application for Revolade 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:
   - ☐ 25mg once daily
   - ☐ 50mg once daily
   - ☐ 75mg once daily
   - ☐ 100mg once daily
   - ☐ Other (please specify): _____

   Provide rationale: _____
2. Health Canada indication (include date of initial diagnosis): Month Year
   - ☐ Immune thrombocytopenia (ITP)
   - ☐ Severe aplastic anemia
   - ☐ Thrombocytopenia related to chronic hepatitis C virus (HCV)

   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 Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

Immune thrombocytopenia (ITP)

Has the patient received previous treatment with corticosteroids and/or immunoglobulin? ☐ Yes ☐ No

Is the patient's platelet count < 30×10^9/L? ☐ Yes ☐ No

Please provide laboratory reports for **2 most recent** baseline levels of platelet count prior to starting eltrombopag olamine therapy.

Thrombocytopenia related to chronic hepatitis C virus (HCV)

Will eltrombopag olamine be used to increase platelet counts to allow the initiation and maintenance of interferon-based therapy? ☐ Yes ☐ No

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

Severe aplastic anemia

Does the patient have a confirmed history of thrombocytopenia? ☐ Yes ☐ No

Has the patient received previous immunosuppressive therapy with antithymocyte globulin (rabbit or horse) plus cyclosporine? ☐ Yes ☐ No

Is the platelet count < 30×10^9/L prior to initiating eltrombopag olamine therapy? ☐ Yes ☐ No

Please provide laboratory reports for **2 most recent** baseline levels of platelet count, hemoglobin and ANC prior to starting eltrombopag olamine therapy.

Renewal - Immune thrombocytopenia (ITP)

Please provide laboratory reports demonstrating most recent platelet count levels.

Describe patient response to eltrombopag olamine treatment: _____

Renewal – Severe aplastic anemia

Please provide laboratory reports demonstrating the most recent platelet count, hemoglobin, and ANC levels.

Describe patient response to eltrombopag olamine treatment: _____

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