Public Service Health Care Plan

Drug Prior Authorization Form

Spravato (esketamine)

PROTECTED "B" WHEN COMPLETED

PART 1 – Instructions

Please use this form to submit your application for Spravato 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. Health Canada indication, prescribed dosage and regimen:

☐ Major Depressive Disorder

Week 1-4 dose: _____ mg administered weekly

Week 5-8 dose: _____ mg administered weekly

Week 9 and onward: _____ mg administered every _____ week(s)

☐ Major Depressive Disorder requiring urgent psychiatric care

☐ 84mg twice per week for 4 weeks

☐ Other (please specify): _____

Provide rationale: _____

Complete questions 1–4 and Patient medical information.

☐ Other (approved by Health Canada): _____

Complete questions 1–4 and Other condition (Health Canada approved).

2. Where will treatment be administered? ☐ Home ☐ Physician's office ☐ Private clinic ☐ Hospital in-patient ☐ Hospital out-patient

3. 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.

_____

_____

4. Drug and treatment history – **must be completed for every request.** If coverage for these drugs was not provided by the PSHCP, please submit a pharmacy printout for the last 12 months.

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:

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

Major Depressive Disorder (MDD)

Is the prescriber enrolled in the JANSSEN JOURNEY™ Program? ☐ Yes ☐ No

Does the patient have a diagnosis of MDD without psychotic features as per DSM-5-TR diagnostic criteria and confirmed by Mini International Neuropsychiatric Interview? ☐ Yes ☐ No

Date of initial diagnosis: Month Year

Current depressive episode

Provide date of onset of current depressive episode, if different from date of initial diagnosis: Month Year

Current ☐ MADRS ☐ PHQ-9 ☐ HAM-D score: _____ Date determined: Day Month Year

For the current depressive episode (select all that apply):

☐ Patient is unable to achieve clinical meaningful improvement with two or more pharmacologically different oral antidepressants at the maximally tolerated effective doses for at least 8 weeks

☐ Patient has tried and failed for at least 4 weeks of two concurrent oral antidepressants OR one antidepressant plus an adjunctive therapy (e.g. antipsychotic)

☐ Other. Please specify: _____

Spravato will be administered (select all that apply):

☐ in combination with an oral antidepressant (either SSRI or SNRI)

☐ under the direct supervision of a health care provider

Complete the Drug and Treatment History chart for current depressive episode. If coverage for these drugs was not provided by the PSHCP, please submit pharmacy printout for the last 12 months.

Renewal Request

Current ☐ MADRS ☐ PHQ-9 ☐ HAM-D score: _____ Date determined: Day Month Year

Note: Must use the same score provided upon initial request

Will Spravato continue to be administered in combination with an oral antidepressant (SSRI or SNRI)? ☐ Yes ☐ No

Major Depressive Disorder requiring urgent psychiatric care

Is the prescriber enrolled in the JANSSEN JOURNEY™ Program? ☐ Yes ☐ No

Will Spravato be used for the treatment of moderate to severe episode of major depressive disorder that requires urgent psychiatric care according to clinical judgement? ☐ Yes ☐ No

Does patient have active suicidal ideation? ☐ Yes ☐ No

Current ☐ MADRS ☐ PHQ-9 ☐ HAM- D score: _____ Date determined: Day Month Year

Will Spravato be used in combination with newly initiated or optimized oral antidepressant therapy? ☐ Yes ☐ No

Please ensure the Drug and Treatment History chart is completed.

Other condition (Health Canada approved)

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

_____

_____

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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