ADVANCED PRIOR AUTHORIZATION REQUEST

Chronic Migraine

INSTRUCTIONS:

1. Please have your physician indicate whether this is an INITIAL prior authorization request or a RENEWAL request by checking the appropriate box in PART 5: PRESCRIBER INFORMATION and then completing ONLY the noted sections.
2. Please have your physician submit the completed form to Merit Mercon Benefitsby email at PA@merconbenefits.com or by fax at 1 (780) 455-6068.
3. If you or your physician have any questions about the prior authorization process, please contact a Plan Administrator at Merit Mercon Benefits at 1 (877) 263-7266 (toll-free) or (780) 455-5845 (Edmonton).
4. Consent is being obtained in accordance with Schedule 1 of the federal Personal Information Protection Electronic Documents Act. If you have any questions regarding the collection, use and disclosure of your personal information, please contact Merit Mercon Benefits' Privacy Officer at 1 (877) 263-7266 (toll-free) or (780) 455-5845.

PART 1: PATIENT INFORMATION		
Plan Member Name:	Patient Name	Patient's Date of Birth (YYYY/MM/DD):
Policy Number:	Certificate Number:	If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: ☐ Spouse ☐ Dependent
Address (number, street, city, province, postal code):		
Phone: ______________________________ E-mail: ______________________________ *Note: Phone is for clarification/request for additional information only*		

PART 2: COORDINATION OF BENEFITS	
Are you currently on, or have previously been on this medication? ☐ Yes ☐ No	If Yes, Start date: (YYYY/MM/DD): ___________________________ Coverage provided by: _______________________________
Do you or your dependants have health benefit coverage through another health benefits company or insurance company? ☐ Yes ☐ No	If Yes, Name of other health benefits company/insurance company: ____ Name of person holding coverage: ___________________________________
Are you currently receiving disability benefits (short-term or long-term) for the condition for which this medication has been prescribed? ☐ Yes ☐ No	
Have you applied for coverage or received any financial support for this medication:	
From another **insurance plan**? ☐ Yes ☐ No	If Yes, name of covered family member: _______________________________ Relationship: ____ Name of Insurance Company: _______________________________________ Outcome: __________________________
From a **provincial program**? ☐ Yes ☐ No	If Yes, name of program(s): ____ **Please attach documentation of acceptance or declination** If No, please explain why the application has not been made: _________________________________
From a **patient assistance / compassionate use program**? ☐ Yes ☐ No	If Yes, name of program(s): ____ Patient assistance program contact name and phone number: Contact Name: __________________ Phone number: ___________________

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PART 3: CURRENT/PAST PHARMACY INFORMATION

Please provide contact details of the pharmacy/pharmacies from which the patient has received medications over the last two years.

Pharmacy Name	Location (Street and City)	Phone #

PART 4: CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

As of the date hereof, I hereby authorize any person or organization who has personal health information about me, including any health care professional (which includes but is not limited to physicians, medical specialists, physiotherapists, pharmacists or any other person who has examined or treated me), health care institution, pharmacy and other medical-related facility, and any authorized agent of mine to release and disclose to Cubic Health Inc. ("Cubic") any personal information regarding my past medical history and current medical condition, including any relevant clinical notes (collectively, the "Personal Information"), which may be required to adjudicate the Request for Prior Authorization to which this Consent forms a part (the "Request").

I authorize Cubic to collect, use and maintain any Personal Information it deems necessary for the purposes of adjudicating the Request or any purposes in any way ancillary thereto.

I understand and agree that Cubic will keep any Personal Information obtained from such persons, organizations and/or agents secure and confidential and in accordance with applicable legislation and that my personal information will not be shared with any other party.

I hereby acknowledge and understand that:

- access to my Personal Information will be limited to Cubic pharmacists and other employees in the course of their employment;
- by filling out the Request, I am not guaranteed approval for any level of coverage;
- Cubic is an independent clinical review panel and is not affiliated with my employer, plan sponsor, plan administrator or insurance company and that Cubic has been engaged for the purpose of ensuring that criteria for the approval of claims are satisfied before approval is granted, and to ensure that the criteria for coverage are implemented consistently;
- Cubic has no interest, financial or otherwise, in the decision rendered in adjudicating the Request;
- Cubic specifically assumes no responsibility for the completeness or accuracy of any Personal Information which may be provided to Cubic in connection with the Request, and Cubic disclaims all liability for any loss or damage suffered by any person, including (without limitation) me, as a result of the processing or outcome of the Request; and
- I have no claim against Cubic for any loss or damage (direct, indirect, incidental, consequential or otherwise) I may suffer as a result of the handling, processing or outcome of the Request.

I understand and agree to the terms above (*If patient is <18 years old, parent/guardian to sign below).*

______________________________	______________________________	______________________________
Full Name (please print)	Signature	Date Signed (YYYY/MM/DD)

MERIT mercon benefits

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Remainder of form should be completed by Physician/Specialist

PART 5: PRESCRIBER INFORMATION

Physician/Prescriber Name:	Specialty:
Registration Number:	Telephone Number:
Address (number, street, city, province, postal code):	Fax Number *(Must be submitted with each request)*:

This request is a: ☐ New Request (please complete *only* Parts 6-9) ☐ Renewal Request (please complete *only* Parts 6 and 10)

PART 6: MEDICATION REQUESTED *(maximum approval for one-year)*

OnabotulinumtoxinA:
☐ Botox 100 unit vial

Other:

Directions for use (i.e. prescription sig):

Where will treatment be administered (e.g. in hospital, in physician's office, at home)?

a) Name of facility: ____
b) If this medication will be administered in a hospital, will the patient be treated as an ☐in-patient or ☐ out-patient?

PART 7: CLINICAL INFORMATION

Diagnosis:
☐ Chronic migraine

☐ Other: ____

The administration of Botulinum Toxin for cosmetic purposes is strictly excluded from coverage.

Date of initial diagnosis (MM/YYYY):	Is the patient currently receiving treatment with Botulinum toxin type A for chronic migraines? ☐ Yes ☐ No
Anticipated duration for treatment: *(max. approval is one year before renewal required)*	Current patient weight:
Does patient have any relevant drug allergies? ☐ Yes ☐ No	Nature of allergy, if applicable: ________________________________

Number of headache days per month in the previous 3 months:			Average duration of continuous headaches (hours):
____________________/month	____________________/month	____________________/month	

Please attach the patient's headache diary

PART 8: RELEVANT CURRENT/PREVIOUS THERAPIES

Medication Name	Dosing Regimen	Start Date (MM/YYYY)	End Date (MM/YYYY)	Patient Response

PART 9: ADDITIONAL INFORMATION

Please provide/attach all relevant clinical information to support medical necessity of medication therapy requested including any relevant lab tests which may support choice of medication therapy:

PART 10: RENEWAL COVERAGE CRITERIA

Please note:

1. Patients who have not obtained an adequate treatment response after 2 treatment cycles will be discontinued from further therapy.
2. Patients who obtain an adequate response, defined as a transition from chronic migraine (≥ 15 headache days per month, with continuous headache lasting ≥ 4 hours AND at least 4 distinct headache episodes each lasting ≥ 4 hours) to episodic migraine (< 15 headache days per month) for 3 continuous months will be discontinued from further therapy.

Number of headache days per month in the previous 3 months:			Average number of headache days per month prior to treatment with botulinum toxin:
___________________/month	___________________/month	___________________/month	

Please attach the patient's headache diary

Please provide/attach any additional clinical information to support the renewal of the requested medication:

I certify that the information provided is true, correct, and complete. Please be advised further information may be requested if needed to facilitate determination of coverage.

Prescribing Physician's signature: ____ Date (YYYY/MM/DD): ___________________________