



ADVANCED PRIOR AUTHORIZATION REQUEST

Multiple Sclerosis

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 Benefits by 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: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Address (number, street, city, province, postal code):		
Phone: _____ E-mail: _____		
<i>Note: Phone is for clarification/request for additional information only</i>		

PART 2: COORDINATION OF BENEFITS

Are you currently on, or have previously been on this medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you applied for coverage or received any financial support for this medication:	
From another insurance plan ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of covered family member: _____ Relationship: _____ Name of Insurance Company: _____ Outcome: _____
From a provincial program ? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ? <input type="checkbox"/> Yes <input type="checkbox"/> 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)



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Remainder of form to 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)

Interferon Beta 1a: Avonex, Rebif, Fingolimod
Interferon Beta 1b: Betaseron, Extavia, Glatiramer Acetate
Peginterferon Beta-1a: Plegridy
Dimethyl Fumarate: Tecfidera
Teriflunomide: Aubagio
Natalizumab: Tysabri
Alemtuzumab: Lemtrada
Other:

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

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

Name of facility: _____

PART 7: CLINICAL INFORMATION

Diagnosis: [] Relapsing-remitting multiple sclerosis [] Secondary-progressive multiple sclerosis [] Other
Patient's Current Expanded Disability Score (EDSS): _____
Date (YYYY/MM/DD): _____
Previous EDSS score (if available): _____
Date (YYYY/MM/DD): _____

Date of initial diagnosis (MM/YYYY):

Patient's current weight:

Qualifying relapses/attacks: Please provide dates of most recent relapses/attacks (an attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 24 hours in the absence of fever, and preceded by stability for at least one month)

Table with 2 columns: Date (YYYY/MM/DD), Type of Relapse (One MRI relapse may substitute for one clinical relapse). Rows include checkboxes for Clinical relapse, MRI relapse, and Other.

If this is NOT the patient's first MS disease modifying therapy (DMT):

Has the patient been on MS DMT since the relapse(s)? [] Yes [] No

Indicate if there have been any interruptions in therapy since starting MS DMT: [] Yes [] No; if Yes, indicate:

- a) Reason for interruption of therapy: _____
b) Time period of interruption: From (YYYY/MM/DD): _____ to (YYYY/MM/DD): _____
c) How many relapses did the patient experience while off therapy? _____



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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

Date patient started current medication (MM/YYYY): _____ Current patient weight: _____

- Evidence of continued benefit (improvement or stabilization) as shown by at least ONE of the following:**
- Reduction in relapse/attack rate (decrease from ___ relapses/attacks per year to ___ relapses/attacks per year)
 - Improvement or stability of EDSS score
 - Most recent EDSS score: _____ Date (YYYY/MM/DD): _____
 - Previous EDSS score: _____ Date (YYYY/MM/DD): _____
 - MRI scan: reduction or stability in lesion load
 - MRI scan: reduction in gadolinium enhancing lesions
 - Overall clinical impression of benefit (please provide details): _____

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): _____