



**ADVANCED PRIOR AUTHORIZATION REQUEST**  
Rheumatoid Arthritis

**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 Mercon Benefit Services by email at [PA@merconbenefits.com](mailto: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 Mercon Benefit Services 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 Mercon Benefit Services' 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	
<b>Have you applied for coverage or received any financial support for this medication:</b>	
From another <b>insurance plan</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of covered family member: _____ Relationship: _____ Name of Insurance Company: _____ Outcome: _____
From a <b>provincial program</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of program(s): _____ <b>Please attach documentation of acceptance or declination</b> If No, please explain why the application has not been made: _____
From a <b>patient assistance / compassionate use program</b> ? <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 ( <i>Must be submitted with each request</i> ):

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*)

<b>Adalimumab:</b> <input type="checkbox"/> Humira 40mg/0.8mL  <b>Abatacept:</b> <input type="checkbox"/> Orencia 250mg vial <input type="checkbox"/> Orencia 125mg syringe  <b>Anakinra</b> <input type="checkbox"/> Kineret 100mg syringe  <b>Certolizumab Pegol</b> <input type="checkbox"/> Cimzia 200mg/mL	<b>Etanercept:</b> <input type="checkbox"/> Enbrel 25mg/kit <input type="checkbox"/> Enbrel 50mg/mL <input type="checkbox"/> Erelzi 50mg/mL <input type="checkbox"/> Brenzys 50mg/mL  <b>Golimumab:</b> <input type="checkbox"/> Simponi 50mg/0.5mL syringe <input type="checkbox"/> Simponi 50mg/0.5mL autoinjector <input type="checkbox"/> Simponi 100mg/mL syringe <input type="checkbox"/> Simponi 100mg/mL autoinjector <input type="checkbox"/> Simponi IV	<b>Infliximab:</b> <input type="checkbox"/> Remicade 100mg vial <input type="checkbox"/> Inflectra 100mg vial <input type="checkbox"/> Remsima 100mg vial  <b>Rituximab:</b> <input type="checkbox"/> Rituxan 10mg/mL <input type="checkbox"/> Rituxan SC 120mg/mL  <b>Sarilumab:</b> <input type="checkbox"/> Kevzara 150mg/1.14mL syringe <input type="checkbox"/> Kevzara 200mg/1.14mL syringe	<b>Tocilizumab</b> <input type="checkbox"/> Actemra IV 80mg/4mL vial <input type="checkbox"/> Actemra IV 200mg/10mL vial <input type="checkbox"/> Actemra IV 400mg/20mL vial <input type="checkbox"/> Actemra 162mg syringe  <b>Tofacitinib:</b> <input type="checkbox"/> Xeljanz 5mg  <b>Other:</b>
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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:	Date of initial diagnosis (MM/YYYY):
Anticipated duration for treatment ( <i>max. approval is one year before renewal required</i> )	Current patient weight:
Does patient have any relevant drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature of allergy, if applicable: _____

**Scores**  
 DAS28: \_\_\_\_ or PAS/PAS-II: \_\_\_\_      AND      HAQ Score: \_\_\_\_  
 Date (YYYY/MM/DD): \_\_\_\_\_      Date (YYYY/MM/DD): \_\_\_\_\_

68 joint count:	No. of swollen joints:	No. of tender joints:
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Presence of any of the following features:  
 Extraarticular disease (e.g., presence of rheumatoid nodules, RA vasculitis, Felty's syndrome)  
 Positive rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP) antibodies  
 Bony erosions by radiograph

Will the patient be maintained on methotrexate (MTX) in combination with the requested medication?  
 Yes    No (if not, please specify reason): \_\_\_\_\_



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**PART 8: RELEVANT CURRENT/PREVIOUS THERAPIES**  
*(including ALL immunosuppressants, prior biologics, steroids, and topical therapies)*

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

If a **switch** to a **different biological agent** is requested, please provide reason:

**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: \_\_\_\_\_

**Scores**  
 DAS28: \_\_\_\_ or PAS/PAS-II: \_\_\_\_ AND HAQ Score: \_\_\_\_  
 Date (YYYY/MM/DD): \_\_\_\_\_ Date (YYYY/MM/DD): \_\_\_\_\_

*68 joint count:* No. of swollen joints: \_\_\_\_\_ No. of tender joints: \_\_\_\_\_

- Presence of any of the following features:
- Extraarticular disease (e.g., presence of rheumatoid nodules, RA vasculitis, Felty's syndrome)
  - Positive rheumatoid factor or anti-cyclic citrulinated peptide (anti-CCP) antibodies
  - Bony erosions by radiograph

Concurrent DMARD therapy:	Medication	Dose	Route	Frequency
OR				
<input type="checkbox"/> Mark here if none				

*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): \_\_\_\_\_