

**Remicade (Infliximab)**

The purpose of this form is to obtain the medical information required to assess your request for a drug on the Prior Authorization list under your drug plan benefit coverage. To avoid delays in processing your request, please ensure that all information, including contact information is complete. Completion of this form is not a guarantee of approval. If you have already purchased the drug, please attach all original receipts along with an Extended Health Care Claim form. All costs incurred to complete this form are the plan member's responsibility. If you are registered for the Plan Member Secure Site and have provided an email address, you will receive an email notification when the prior authorization decision is available on your claims statement. If you are not registered on the Plan Member Secure Site, you will be notified of the prior authorization decision by mail.

**Important: Please ensure the most current unaltered version of the form is completed and signed. To download the most recent version of the Drug Prior Authorization form go to [www.manulife.ca](http://www.manulife.ca).**

| <b>1 – Plan member and patient information</b> |  |                                    |                                |                         |              | <b>To be completed by plan member</b>  |             |
|------------------------------------------------|--|------------------------------------|--------------------------------|-------------------------|--------------|----------------------------------------|-------------|
| Plan contract number                           |  |                                    | Plan member certificate number |                         | Plan sponsor |                                        |             |
| Plan member name (first)                       |  | Plan member name (middle initial)  |                                | Plan member name (last) |              | Plan member Date of birth (dd/mm/yyyy) |             |
| Plan member address (number, street)           |  |                                    | Address (suite)                |                         | City or town |                                        | Province    |
|                                                |  |                                    |                                |                         |              |                                        | Postal code |
| Patient name (first)                           |  | Patient name (middle initial)      |                                | Patient name (last)     |              | Patient date of birth (dd/mm/yyyy)     |             |
|                                                |  |                                    |                                |                         |              | Relationship to plan member            |             |
| Patient's preferred daytime phone number       |  | Patient's email address (optional) |                                |                         |              |                                        |             |
|                                                |  |                                    |                                |                         |              |                                        |             |

| <b>1A – Other Group Plan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>1B – Recent Coverage Change</b> |  |                      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--|----------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Does the patient have drug coverage under any other group plan? If Yes, please complete below: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;">Name of insurance company</td> </tr> <tr> <td style="padding: 5px;">Plan contract number</td> <td style="padding: 5px;">Plan member certificate number</td> </tr> </table> <p>Is this drug covered under the other group plan? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If no, why was the drug declined by the other group plan? Please attach the other group plan decline notice (typically a letter or statement). We need this decline notice to see if this drug can be approved. If this is a renewal a current decline notice is required.</p> | Name of insurance company          |  | Plan contract number | Plan member certificate number | <p>Did your plan sponsor recently transfer your drug benefits to Manulife? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>Before joining Manulife, were you receiving coverage for this drug through your previous insurance company? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If Yes, attach proof of payment (a copy of a pharmacy receipt showing payment from prior insurance company or an Explanation of Benefits from the prior insurance company). Proceed to section 7.</p> |
| Name of insurance company                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |  |                      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Plan contract number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Plan member certificate number     |  |                      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| <b>2 – Provincial Plans</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>To be completed by plan member</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| <p>Most provinces offer some form of drug coverage to their residents. Your Manulife drug plan supplements the coverage provided by provincial plans. It is important that you or your doctor (if required) apply to the applicable provincial program to ensure there are no delays in your drug reimbursement. Check with your doctor or login to the <b>Manulife Provincial Drug Plans Resource Centre</b> on our Plan Member Secure Site at <a href="http://www.manulife.ca/planmember">www.manulife.ca/planmember</a> to confirm if the drug you have been prescribed may be eligible for coverage under a provincial plan. If the drug you have been prescribed is listed under a provincial program, you will need to apply to the program before consideration can be given under your Manulife drug plan.</p> |                                       |
| <p>Has application been made to the provincial program for coverage? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <div style="border: 1px solid black; padding: 5px; min-height: 30px;">If no, why?</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |
| <p>Has the patient been approved for coverage by the provincial program for this drug? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <div style="border: 1px solid black; padding: 5px; min-height: 30px;">If no, advise why the request was declined?</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                       |

**In Ontario, for patients that qualify for coverage under the Exceptional Access Program (EAP), if the drug is an EAP drug, a copy of the approval or denial from EAP must be submitted with this form so Manulife can complete the assessment of this request.**

| <b>3 – Patient Assistance Programs</b>                                                                                                                                                                                          |                          |                    |                                       | <b>To be completed by plan member</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------|---------------------------------------|---------------------------------------|
| <p>Have you enrolled in the Patient Assistance Program for the requested drug? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If yes, please provide the details below:</p> |                          |                    |                                       |                                       |
| Case Manager Name (first)                                                                                                                                                                                                       | Case Manager name (last) | Case Manager Phone | Case Manager Email                    |                                       |
| Patient Assistance Program Name                                                                                                                                                                                                 |                          |                    | Patient Assistance Program ID Number: |                                       |

| 4 – Medical information                                                                                                                                                                                                                                                  |  |                                              |              | To be completed by prescribing physician                 |             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--------------|----------------------------------------------------------|-------------|
| Drug strength and dosage                                                                                                                                                                                                                                                 |  |                                              |              |                                                          |             |
| Where will treatment be administered?                                                                                                                                                                                                                                    |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Home                                                                                                                                                                                                                                            |  | <input type="checkbox"/> MD office           |              | <input type="checkbox"/> Private Clinic                  |             |
|                                                                                                                                                                                                                                                                          |  | <input type="checkbox"/> Hospital/In-Patient |              | <input type="checkbox"/> Hospital/Out-patient            |             |
| Is the MD office located in a hospital?                                                                                                                                                                                                                                  |  |                                              |              |                                                          |             |
|                                                                                                                                                                                                                                                                          |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered in the MD office or in another area of the hospital? (describe below)                                                                                                                                                                      |  |                                              |              |                                                          |             |
|                                                                                                                                                                                                                                                                          |  |                                              |              |                                                          |             |
| If the treatment is not being administered at home, please provide:                                                                                                                                                                                                      |  |                                              |              |                                                          |             |
| Name of private clinic/hospital                                                                                                                                                                                                                                          |  |                                              |              | Telephone number                                         |             |
| Address (number, street)                                                                                                                                                                                                                                                 |  | Address (suite)                              | City or town |                                                          | Province    |
|                                                                                                                                                                                                                                                                          |  |                                              |              |                                                          | Postal code |
| Please select the diagnosis for which the drug has been prescribed and respond to the corresponding questions.                                                                                                                                                           |  |                                              |              |                                                          |             |
| <input type="checkbox"/> <b>Rheumatoid Arthritis - Initial Criteria</b>                                                                                                                                                                                                  |  |                                              |              |                                                          |             |
| Provide current score of at least one of the following:                                                                                                                                                                                                                  |  |                                              |              |                                                          |             |
| Disease Activity Score in 28 joints (DAS28)                                                                                                                                                                                                                              |  | Clinical Disease Activity Index (CDAI)       |              | Simplified Disease Activity Index (SDAI)                 |             |
|                                                                                                                                                                                                                                                                          |  |                                              |              |                                                          |             |
| Choose one of the following:                                                                                                                                                                                                                                             |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Patient has a positive Rheumatoid Factor (RF)                                                                                                                                                                                                   |  |                                              |              | Number of swollen joints                                 |             |
| <input type="checkbox"/> Patient has positive Anti-CCP antibodies                                                                                                                                                                                                        |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Patient has radiographic evidence of rheumatoid arthritis                                                                                                                                                                                       |  |                                              |              |                                                          |             |
| Has the patient tried Methotrexate and one other Disease-Modifying Antirheumatic Drug (DMARD)?                                                                                                                                                                           |  |                                              |              |                                                          |             |
|                                                                                                                                                                                                                                                                          |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| If Yes, please provide the number of weeks of therapy                                                                                                                                                                                                                    |  |                                              |              |                                                          |             |
|                                                                                                                                                                                                                                                                          |  |                                              |              |                                                          |             |
| Note: For new submissions, if the patient is part of one of the population groups listed below and if eligibility criteria have been met, the approval for coverage will only be applicable to the preferred infliximab treatment option – Inflectra or Renflexis.       |  |                                              |              |                                                          |             |
| Please select the appropriate population group for this patient:                                                                                                                                                                                                         |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Resident of British Columbia                                                                                                                                                                                                                    |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Resident of Alberta and over 65 years of age                                                                                                                                                                                                    |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Resident of Manitoba                                                                                                                                                                                                                            |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Resident of Ontario and over 65 years of age                                                                                                                                                                                                    |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Resident of Quebec and over 65 years of age                                                                                                                                                                                                     |  |                                              |              |                                                          |             |
| If there is a medical reason why Inflectra or Renflexis is not an option for this patient please indicate reason(s) here                                                                                                                                                 |  |                                              |              |                                                          |             |
|                                                                                                                                                                                                                                                                          |  |                                              |              |                                                          |             |
| Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval. |  |                                              |              |                                                          |             |
| <input type="checkbox"/> <b>Rheumatoid Arthritis - Renewal Criteria</b>                                                                                                                                                                                                  |  |                                              |              |                                                          |             |
| Is there documented objective evidence of continued benefit for the patient:                                                                                                                                                                                             |  |                                              |              |                                                          |             |
| Reduction in swollen joint count from baseline.                                                                                                                                                                                                                          |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| OR                                                                                                                                                                                                                                                                       |  |                                              |              |                                                          |             |
| Reduction in PAS or PAS II.                                                                                                                                                                                                                                              |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| OR                                                                                                                                                                                                                                                                       |  |                                              |              |                                                          |             |
| CDAI, or DAS28 or SDAI scores.                                                                                                                                                                                                                                           |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |

| 4 – Medical information (continued)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | To be completed by prescribing physician                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> <b>Ankylosing Spondylitis - Initial Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          |
| Has the patient had an inadequate/suboptimal response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the patient allergic to non-steroidal anti-inflammatory drugs (NSAIDs)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Current Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                          |
| <p>Note: For new submissions, if the patient is part of one of the population groups listed below and if eligibility criteria have been met, the approval for coverage will only be applicable to the preferred infliximab treatment option – Inflectra or Renflexis.</p> <p>Please select the appropriate population group for this patient:</p> <p><input type="checkbox"/> Resident of British Columbia</p> <p><input type="checkbox"/> Resident of Alberta and over 65 years of age</p> <p><input type="checkbox"/> Resident of Manitoba</p> <p><input type="checkbox"/> Resident of Ontario and over 65 years of age</p> <p><input type="checkbox"/> Resident of Quebec and over 65 years of age</p> |                                                          |
| If there is a medical reason why Inflectra or Renflexis is not an option for this patient please indicate reason(s) here                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                          |
| <p>Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.</p>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                          |
| <input type="checkbox"/> <b>Ankylosing Spondylitis - Renewal Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          |
| Has the patient experienced clinical benefit from treatment?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> <b>Moderate to Severely Active Psoriatic Arthritis - Initial Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          |
| Has patient had an inadequate/suboptimal response to at least two non-steroidal anti-inflammatory drugs (NSAID) or one disease-modifying antirheumatic drug (DMARD)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>Note: For new submissions, if the patient is part of one of the population groups listed below and if eligibility criteria have been met, the approval for coverage will only be applicable to the preferred infliximab treatment option – Inflectra or Renflexis.</p> <p>Please select the appropriate population group for this patient:</p> <p><input type="checkbox"/> Resident of British Columbia</p> <p><input type="checkbox"/> Resident of Alberta and over 65 years of age</p> <p><input type="checkbox"/> Resident of Manitoba</p> <p><input type="checkbox"/> Resident of Ontario and over 65 years of age</p> <p><input type="checkbox"/> Resident of Quebec and over 65 years of age</p> |                                                          |
| If there is a medical reason why Inflectra or Renflexis is not an option for this patient please indicate reason(s) here                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                          |
| <p>Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.</p>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                          |
| <input type="checkbox"/> <b>Moderate to Severely Active Psoriatic Arthritis - Renewal Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          |
| Has the patient experienced clinical benefit from treatment?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| 4 – Medical information (continued)                                                                                                                                                                                                                                                                                              |                                             | To be completed by prescribing physician               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> <b>Plaque Psoriasis - Initial Criteria</b>                                                                                                                                                                                                                                                              |                                             |                                                        |
| Psoriasis Area and Severity Index (PASI) score                                                                                                                                                                                                                                                                                   | Body Surface Area (BSA) Involvement %       |                                                        |
| Has patient had an inadequate/suboptimal response to phototherapy? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>                                                                                                                                                                 |                                             |                                                        |
| Note: For new submissions, if the patient is part of one of the population groups listed below and if eligibility criteria have been met, the approval for coverage will only be applicable to the preferred infliximab treatment option – Inflectra or Renflexis.                                                               |                                             |                                                        |
| Please select the appropriate population group for this patient:                                                                                                                                                                                                                                                                 |                                             |                                                        |
| <input type="checkbox"/> Resident of British Columbia<br><input type="checkbox"/> Resident of Alberta and over 65 years of age<br><input type="checkbox"/> Resident of Manitoba<br><input type="checkbox"/> Resident of Ontario and over 65 years of age<br><input type="checkbox"/> Resident of Quebec and over 65 years of age |                                             |                                                        |
| If there is a medical reason why Inflectra or Renflexis is not an option for this patient please indicate reason(s) here                                                                                                                                                                                                         |                                             |                                                        |
| Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.                                                         |                                             |                                                        |
| <input type="checkbox"/> <b>Plaque Psoriasis - Renewal Criteria</b>                                                                                                                                                                                                                                                              |                                             |                                                        |
| Has the patient experienced clinical benefit from treatment? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>                                                                                                                                                                       |                                             |                                                        |
| <input type="checkbox"/> <b>Crohn's Disease - Initial Criteria</b>                                                                                                                                                                                                                                                               |                                             |                                                        |
| Provide current score of at least one of the following:                                                                                                                                                                                                                                                                          |                                             |                                                        |
| Current Harvey Bradshaw Index score                                                                                                                                                                                                                                                                                              | Crohn's Disease Activity Index (CDAI) score | Pediatric Crohn's Disease Activity Index (PCDAI) score |
| Note: For new submissions, if the patient is part of one of the population groups listed below and if eligibility criteria have been met, the approval for coverage will only be applicable to the preferred infliximab treatment option – Inflectra or Renflexis.                                                               |                                             |                                                        |
| Please select the appropriate population group for this patient:                                                                                                                                                                                                                                                                 |                                             |                                                        |
| <input type="checkbox"/> Resident of British Columbia<br><input type="checkbox"/> Resident of Alberta and over 65 years of age<br><input type="checkbox"/> Resident of Manitoba<br><input type="checkbox"/> Resident of Ontario and over 65 years of age<br><input type="checkbox"/> Resident of Quebec and over 65 years of age |                                             |                                                        |
| If there is a medical reason why Inflectra or Renflexis is not an option for this patient please indicate reason(s) here                                                                                                                                                                                                         |                                             |                                                        |
| Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.                                                         |                                             |                                                        |
| <input type="checkbox"/> <b>Crohn's Disease - Renewal Criteria</b>                                                                                                                                                                                                                                                               |                                             |                                                        |
| Has the patient experienced clinical benefit from treatment? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>                                                                                                                                                                       |                                             |                                                        |

| 4 – Medical information (continued)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | To be completed by prescribing physician |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> <b>Fistulating Crohn's Disease - Initial Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                          |
| Does the patient have fistula(e) that is actively draining? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                          |
| <p>Note: For new submissions, if the patient is part of one of the population groups listed below and if eligibility criteria have been met, the approval for coverage will only be applicable to the preferred infliximab treatment option – Inflectra or Renflexis.</p> <p>Please select the appropriate population group for this patient:</p> <p><input type="checkbox"/> Resident of British Columbia</p> <p><input type="checkbox"/> Resident of Alberta and over 65 years of age</p> <p><input type="checkbox"/> Resident of Manitoba</p> <p><input type="checkbox"/> Resident of Ontario and over 65 years of age</p> <p><input type="checkbox"/> Resident of Quebec and over 65 years of age</p> |                                          |
| If there is a medical reason why Inflectra or Renflexis is not an option for this patient please indicate reason(s) here                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                          |
| <p>Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.</p>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |
| <input type="checkbox"/> <b>Fistulating Crohn's Disease - Renewal Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                          |
| Has the patient experienced clinical benefit from treatment? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| <input type="checkbox"/> <b>Moderately to Severely Active Ulcerative Colitis - Initial Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| <p>Note: For new submissions, if the patient is part of one of the population groups listed below and if eligibility criteria have been met, the approval for coverage will only be applicable to the preferred infliximab treatment option – Inflectra or Renflexis.</p> <p>Please select the appropriate population group for this patient:</p> <p><input type="checkbox"/> Resident of British Columbia</p> <p><input type="checkbox"/> Resident of Alberta and over 65 years of age</p> <p><input type="checkbox"/> Resident of Manitoba</p> <p><input type="checkbox"/> Resident of Ontario and over 65 years of age</p> <p><input type="checkbox"/> Resident of Quebec and over 65 years of age</p> |                                          |
| If there is a medical reason why Inflectra or Renflexis is not an option for this patient please indicate reason(s) here                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                          |
| <p>Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.</p>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |
| <input type="checkbox"/> <b>Moderately to Severely Active Ulcerative Colitis - Renewal Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| Has the patient experienced clinical benefit from treatment? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| <input type="checkbox"/> <b>Any Other Diagnosis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| Please provide the specific diagnosis and any Canadian clinical research that supports the use of this drug in your patient's context.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |

| 5 – Drug history                                                                                                                                                                                                                                                                                                                                                                                                     |                                     |                        | To be completed by prescribing physician                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| If no previous therapies have been tried for the selected diagnosis, please specify the rationale:<br><input type="checkbox"/> Risk of drug interaction <input type="checkbox"/> Patient has contraindication<br><input type="checkbox"/> Other                                                                                                                                                                      |                                     |                        |                                                                                                                                             |
| Please provide medical rationale                                                                                                                                                                                                                                                                                                                                                                                     |                                     |                        |                                                                                                                                             |
| <b>For the selected diagnosis, please provide all previous and current drug therapies in the area below:</b>                                                                                                                                                                                                                                                                                                         |                                     |                        |                                                                                                                                             |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm)               | End date (yyyy/mmm)    | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                                     |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm)               | End date (yyyy/mmm)    | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                                     |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm)               | End date (yyyy/mmm)    | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                                     |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm)               | End date (yyyy/mmm)    | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                                     |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| <b>6 – Physician information</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                     |                        | To be completed by prescribing physician                                                                                                    |
| Prescribing physician's name (first)                                                                                                                                                                                                                                                                                                                                                                                 | Prescribing physician's name (last) | College/License Number | Specialty                                                                                                                                   |
| Address (number, street)                                                                                                                                                                                                                                                                                                                                                                                             |                                     |                        | Address (suite)                                                                                                                             |
| City or town                                                                                                                                                                                                                                                                                                                                                                                                         | Province                            | Postal code            |                                                                                                                                             |
| Telephone number                                                                                                                                                                                                                                                                                                                                                                                                     | Extension                           | Fax number             |                                                                                                                                             |
| <b>Physician authorization</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                     |                        |                                                                                                                                             |
| I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits health file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein. |                                     |                        |                                                                                                                                             |
| Physician Signature                                                                                                                                                                                                                                                                                                                                                                                                  |                                     |                        | Date (dd/mmm/yyyy)                                                                                                                          |

**I certify** that I, my spouse and/or my dependents of minor or major age ("Dependents") require the drug named on this form (or an equivalent drug that Manulife proposes).

**I authorize:**

Manulife and/or its service providers, its reinsurers, and their service providers to collect, use, maintain and disclose my personal information related to this application ("Personal Information") for the purposes of:

- The assessment of the drug authorization request
- Managing my Group Benefits plan
- Assessing and processing claims
- Auditing and investigation of claims
- Patient assistance programs, if applicable
- And/or other purposes identified in the Personal Information Statement for Employers' Group Benefits plans (collectively, the "Purposes").

Any person or organization who has Personal Information about me that is required for Manulife to assess this drug authorization request, including any medical and health care professionals, institution, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.

**I understand:**

- A Manulife approved pharmacy vendor may engage me in the capacity of case management to provide support as part of this program. I acknowledge that participation in this program is entirely voluntary. My decision to participate will not have any impact on the assessment of my claim.
- If my Manulife plan recommends purchasing a drug that requires prior authorization from a preferred pharmacy or provider, a case manager may contact me, my doctor and/or patient assistance program to arrange to have my prescription(s) transferred to the preferred pharmacy or provider.
- That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and may be subject to the laws of those jurisdictions.
- I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind or terminate my claim.

**I agree:**

- A photocopy or electronic version of this consent is valid.
- I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate.
- Requests can be sent to: Privacy Officer Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6 or [Canada\\_Privacy@manulife.ca](mailto:Canada_Privacy@manulife.ca)
- For more information, I can review the [Personal Information Statement for Employers' Group Benefits Plans](#) and the [Canadian Privacy Policy](#).

**I confirm** that:

- The information I have given in this request is true and accurate.
- By signing, I give permission to and/or confirm that I have obtained the individual's consent for the collection, use, disclosure or otherwise processing of the individual's Personal Information for the Purposes (as these terms are defined above).

Plan member's signature

Date signed (dd/mm/yyyy)

Protecting your personal information is important to us. People who can see your personal information are:

- Manulife employees who need to see your information to do their jobs.
- People you've given permission to.

To find out more about Manulife's privacy policy please see [manulife.ca](http://manulife.ca)

## 8 – Submission instructions

### Plan Member Secure Site

1. Log in to the **Plan Member Secure Site**.
2. Choose “**Claims**”
3. Go to “**Submit a Claim.**”
4. Under **Service Provider**, select “**Other.**”
5. Choose “**Estimate**” as the **Claim Type**.

### Mobile App Site

1. Open the **Mobile Site** on your device.
2. Select “**Submit a Claim.**”
3. Choose “**Estimate**” as the **Claim Type**.

### Mail or fax

If you live in Quebec:

Manulife Group Benefits Health Claims  
Attention Prior Authorization Team  
PO BOX 2580, STATION B  
MONTREAL QC H3B 5C6

Fax: 1-855-752-0404

If you live outside Quebec:

Manulife Group Benefits Health Claims  
Attention Prior Authorization Team  
PO BOX 1653  
WATERLOO ON N2J 4W1

Fax: 1-855-752-0404

Please retain a photocopy for your files.

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