Manulife

Group Benefits
Drug Prior Authorization

Soliris (Eculizumab)

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.

1 – Plan member and patient information — To be completed by plan member

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/mmm/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/mmm/yyyy)	Relationship to plan member

Patient's preferred daytime phone number	Patient's email address (optional)

1A – Other Group Plan

Does the patient have drug coverage under any other group plan? If Yes, please complete below: ☐ Yes ☐ No

Name of insurance company	
Plan contract number	Plan member certificate number

Is this drug covered under the other group plan? ☐ Yes ☐ No

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.

1B – Recent Coverage Change

Did your plan sponsor recently transfer your drug benefits to Manulife? ☐ Yes ☐ No

Before joining Manulife, were you receiving coverage for this drug through your previous insurance company ☐ Yes ☐ No

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.

2 – Provincial Plans — To be completed by plan member

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 **Manulife Provincial Drug Plans Resource Centre** on our Plan Member Secure Site at www.manulife.ca/planmember 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.

Has application been made to the provincial program for coverage? ☐ Yes ☐ No

If no, why?

Has the patient been approved for coverage by the provincial program for this drug? ☐ Yes ☐ No

If no, advise why the request was declined?

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.

3 – Patient Assistance Programs — To be completed by plan member

Have you enrolled in the Patient Assistance Program for the requested drug? ☐ Yes ☐ No

If yes, please provide the details below:

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?

☐ Home ☐ MD office ☐ Private Clinic ☐ Hospital/In-Patient ☐ Hospital/Out-patient

Is the MD office located in a hospital? ☐ Yes ☐ 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.

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) - Initial Criteria

Has patient had at least one transfusion during the past two years? ☐ Yes ☐ No

Will patient be vaccinated with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of Soliris? ☐ Yes ☐ No

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) - Renewal Criteria

Does patient show a stabilization of hemoglobin concentration from baseline? ☐ Yes ☐ No

Please indicate patient's Hb count prior to starting Soliris:	Please indicate patient's Hb count 12 months after starting Soliris:

Does patient show a reduction in red-cell transfusion requirement from baseline? ☐ Yes ☐ No

Does patient show a reduction in intravascular hemolysis from baseline? ☐ Yes ☐ No

Please indicate patient's serum lactate dehyhdrogenase (LDH) concentration prior to starting Soliris:	Please indicate patient's serum lactate dehyhdrogenase (LDH) concentration 12 months after starting Soliris:

Does patient show an improvement in patient's quality of life from baseline? ☐ Yes ☐ No

Please provide all evidence that would justify the continued use of Soliris by this patient:

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

☐ Atypical Hemolytic Uremic Syndrome (atypical HUS) - Initial Criteria

Will patient be vaccinated with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of Soliris? ☐ Yes ☐ No

Is ADAMTS-13 activity >10% on blood samples taken prior to PE/PI? ☐ Yes ☐ No

Does patient have Shiga toxin-producing E.coli related hemolytic uremic syndrome (STEC-HUS)? ☐ Yes ☐ No

Is there absence of an alternative diagnosis that is unlikely to respond to Soliris (i.e., disseminated intravascular coagulation, lupus, etc)? ☐ Yes ☐ No

Is there evidence of ongoing active thrombotic microangiopathy (TMA) as defined by laboratory test abnormalities despite plasmapheresis (minimum of 4 plasma exchanges required over 4 successive days)? ☐ Yes ☐ No

Does patient have a platelet count <150 x 10^9/L and evidence of hemolysis? ☐ Yes ☐ No

4 – Medical information (continued)	To be completed by prescribing physician

If patient does not have evidence of platelet consumption and hemolysis, is there tissue biopsy confirming active thrombotic microangiopathy? ☐ Yes ☐ No

There is evidence of the following documented clinical feature(s) of active organ damage or impairment (check all that apply):

- Kidney impairment ☐
- Onset of neurological impairment related to active thrombotic microangiopathy ☐

Will drug be administered under the supervision of a qualified health professional familiar with treating atypical HUS? ☐ Yes ☐ No

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

☐ Atypical Hemolytic Uremic Syndrome (atypical HUS) - Renewal Criteria

Does patient show hematological normalization? ☐ Yes ☐ No

Is there decrease in serum lactate dehyhdrogenase (LDH) concentration from baseline? ☐ Yes ☐ No

Please indicate patient's serum lactate dehyhdrogenase (LDH) concentration prior to starting Soliris:	Please indicate patient's serum lactate dehyhdrogenase (LDH) concentration 12 months after starting Soliris:

Is there an increase in platelet count from baseline? ☐ Yes ☐ No

Please indicate patient's platelet count prior to starting Soliris:	Please indicate patient's platelet count 12 months after starting Soliris:

Is there an improvement or stabilization of estimated glomerular filtration rate (eGFR) or in serum creatinine (SrCr) from baseline? ☐ Yes ☐ No

Please indicate patient's eGFR prior to starting Soliris:	Please indicate patient's eGFR 12 months after starting Soliris:

Is there stabilization of neurological or extra-renal impairment if originally present? ☐ Yes ☐ No

Please provide all evidence that would justify the continued use of Soliris by this patient:

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

☐ Generalized Myasthenia Gravis (gMG) - Initial Criteria

Does patient have a Myasthenia Gravis-Activities of Daily Living score of ≥6 and has MGFA class II-IV disease? ☐ Yes ☐ No

Has patient had treatment failure with two or more immunosuppressive therapies (ISTs) either in combination or as monotherapy for 12 months without symptom control? ☐ Yes ☐ No

Has patient failed at least one IST and requires chronic plasmapheresis, plasma exchange (PE), or intravenous immunoglobulin (IVIg) to control symptoms for at least 12 months? ☐ Yes ☐ No

Is patient positive for the anti-acetylcholine receptor antibody (AChR+ R-gMG)? ☐ Yes ☐ No

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

☐ Generalized Myasthenia Gravis (gMG) - Renewal Criteria

Is there MGFA post-intervention status of improved or minimal manifestations status? ☐ Yes ☐ No

Is there an improvement in the Myasthenia Gravis-ADL score from baseline or the Myasthenia Gravis-ADL score remains the same? ☐ Yes ☐ No

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

4 – Medical information	To be completed by prescribing physician

☐ **Neuromyelitis Optica Spectrum Disorder (NMOSD) - Initial Criteria**

Expanded Disability Status Scale (EDSS) score

Will drug be used for acute treatment of an NMOSD relapse?	☐ Yes	☐ No
Does patient have a history of at least two relapses in last 12 months or three relapses in the last 24 months (with at least one relapse in the 12 months prior to starting treatment)?	☐ Yes	☐ No
Has patient tried and failed treatment with Enspryng?	☐ Yes	☐ No
Has patient tried and failed treatment with Uplizna?	☐ Yes	☐ No

Please provide medical reason why Enspryng or Uplizna cannot be used:

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

☐ **Neuromyelitis Optica Spectrum Disorder (NMOSD) - Renewal Criteria**

Is there an improvement or stabilization of neurologic symptoms as evidenced by a decrease in acute relapses, EDSS, or hospitalizations?	☐ Yes	☐ No

Note: Initial and subsequent approvals are limited to 12 months. Additional information is required every 12 months, in order to assess for further coverage.

☐ **Any Other Diagnosis**

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:

☐ Risk of drug interaction ☐ Patient has contraindication

☐ Other

Please provide medical rationale

For the selected diagnosis, please provide all previous and current drug therapies in the area below:

Drug name	Start date (yyyy/mmm)	End date (yyyy/mmm)	Specify Outcome:
			☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No

6 – Physician information — 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

Physician authorization

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)

7 – Authorization and Plan member signature — To be signed by plan member

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
- 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/mmm/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

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.