INFORMATION REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

ENTYVIO (Vedolizumab)

SECTION 1 – INFORMATION ON THE MEMBER

Member name:	Group number:	Certificate number:
Address (No. / Street / Apt.):		
City :	Province :	Postal Code :
Phone number :	E-mail address :	
Employer name / Policy holder: :	Group / Division number:	

SECTION 2 – INFORMATION ON THE PATIENT

Patient name:	
Patient Date of Birth (YYYY/MM/DD):	Relationship to member:

Have you applied for coverage with a provincial program? ☐ Yes ☐ No

Has your application for coverage with the provincial program for this drug or supply been approved? ☐ Yes ☐ No

If you have applied for coverage with a provincial program, please provide us with a copy of the refusal or acceptance letter.

Are you enrolled in a drug manufacturer's patient assistance program? ☐ Yes ☐ No

If yes, please provide your patient assistance program identification number : _____

SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION

I authorize any health professional (doctor, pharmacist, dentist), any person (service provider), any other insurance company, any public or private health institution, any government agency in relation to health or social services, to disclose and exchange requested information by the insurer or AGA Benefits Solutions, necessary for the evaluation of my request for prior authorization for that drug.

Patient signature:	Date:
Signature of the subscriber when patient is a minor:	Date:

SECTION 4 - DRUG COVERED BY THE APPLICATION

Drug Name:			
Dosage:			
Pharmaceutical Form:		Content / Strength:	
Anticipated duration of treatment:	From (YYYY/MM/DD) :	To (YYYY/MM/DD) :	
Diagnosis:		Initial date of diagnosis (YYYY-MM-DD):	

Medication will be administered at the following location:

☐ Home ☐ Health and social service center ☐ Long-term care center ☐ Private clinic

☐ Hospital - internal patient ☐ Hospital - external patient ☐ Elsewhere. Specify : _____

If the treatment is not administered at home, please provide the following information:

Name of the location where the drug will be administered:		Telephone:	
Address (No. / Street / Apt.):	City :	Province:	Postal Code :

SECTION 5 - TYPE OF APPLICATION

☐ Initial request ☐ Continued treatment ☐ Modification of treatment

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SECTION 6- SUMMARY OF PREVIOUS TRIALS OR CONTRAINDICATIONS

Please provide a list of medicines and/or treatments used to date to control this condition:

Name of drug/treatment currently or previously prescribed	Content - strength / Dosage	Trial Period		Reason for Discontinuation
		From (YYYY-MM-DD)	To (YYYY-MM-DD)	
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____

SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

DIAGNOSIS

☐ Ulcerative colitis

☐ Crohn's disease

☐ Other. Specify : _____

ULCERATIVE COLITIS

Is the activity of the ulcerative colitis moderate to severe ? ☐ Moderate ☐ Severe

Was the drug started at hospital? ☐ Yes ☐ No

If yes, specify the following information: Admission date (YYYY/MM/DD) : _____ Discharge date (YYYY/MM/DD) : _____

Please provide the following pre-treatment information as well as the date on which they were obtained :

MAYO Initail assessment : _____ Date (YYYY/MM/DD) : _____

Mayo endoscopic subscore Initail assessment : _____ Date (YYYY/MM/DD) : _____

Rectal bleeding subscore Initail assessment : _____ Date (YYYY/MM/DD) : _____

Partial Mayo score Initail assessment : _____ Date (YYYY/MM/DD) : _____

Will the drug be taken in combination with other treatment for ulcerative colitis? ☐ Yes ☐ No

If yes, specify the treatment(s) : _____

Please provide information to support starting advanced therapy without adequate trial of conventional therapy :

_____

CROHN'S DISEASE

Please specify the form of the condition: ☐ Moderate ☐ Severe

Site de la maladie et complications : _____

Please provide the following pre-treatment information as well as the date on which they were obtained :

HBI Initail assessment : _____ Date (YYYY/MM/DD) : _____

C-reactive protein value Initail assessment : _____ Date (YYYY/MM/DD) : _____

CDAI Initail assessment : _____ Date (YYYY/MM/DD) : _____

Sedimentation rate Initail assessment : _____ Date (YYYY/MM/DD) : _____

Has the patient been hospitalized for this condition? ☐ Yes ☐ No

If yes, specify the following information: Admission date (YYYY/MM/DD) : _____ Discharge date (YYYY/MM/DD) : _____

Was the drug started at hospital? ☐ Yes ☐ No

If yes, please submit the following information: Date of infusion and dosage (YYYY/MM/DD) : _____

Date of next scheduled dose (YYYY/MM/DD) : _____

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SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION (CONT.)

CROHN'S DISEASE (CONT.)

Will the drug be taken in combination with other treatment for Crohn's disease? ☐ Yes ☐ No

If yes, please specify: _____

SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

ULCERATIVE COLITIS

Please provide the **recent** following information as well as the date on which they were obtained :

MAYO	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
Mayo endoscopic subscore	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
Rectal bleeding subscore	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
Partial Mayo score	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____

CROHN'S DISEASE

Please provide the **recent** following information as well as the date on which they were obtained :

CDAI	Initail assessment : _____	Recent assessment : _____	Date (YYYY/MM/DD) : _____
HBI	Initail assessment : _____ mg/L	Recent assessment : _____	Date (YYYY/MM/DD) : _____

SECTION 9– ADDITIONAL INFORMATION (optional)

SECTION 10 – SIGNATURE OF AUTHORIZED PRESCRIBER

Print name of authorized prescriber:	Specialty of the physician:	
Signature of authorized prescriber:	License Number:	Date :

SECTION 11 - IMPORTANT PATIENT INFORMATION

Fees may be charged to complete this form, it is the patient's responsibility to pay them.
Ensure all required sections of the form have been completed and signed before returning it.
Attach any additional documents required on this form.
Your request may be delayed if we do not have all the necessary information.
The drug will be eligible only if it meets the criteria established by the insurer.

HOW TO RETURN THE FORM

By email : **exceptions@aga.ca** By fax: (514) 935-1147	By mail : AGA Benefit Solutions 3500 de Maisonneuve Blvd. W, suite 2200 Westmount (QC) H3Z 3C1