AGA BENEFIT SOLUTIONS

INFORMATION REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

ADALIMUMAB (Abrilada, Amgevita, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Simlandi, Yuflyma)

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 From (YYYY-MM-DD)	Trial Period To (YYYY-MM-DD)	Reason for Discontinuation
				☐ 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

BIOLOGIC DRUG

Authorization requests for the biologic drug **HUMIRA** will no longer be considered, except in rare cases, since biosimilar medications are now available. If the patient is in a situation that prevents them from transitioning to a biosimilar version of **HUMIRA**, please indicate it below:

☐ Pregnant woman – Expected delivery date (AAAA/MM/JJ) : _____

☐ Pediatric patient

☐ Patient who has experienced therapeutic failure with at least two other biologic medications

Please specify the biologic medications tried : _____

☐ Other – Please provide sufficiently documented medical justification.

DIAGNOSIS

☐ Juvenile Idiopathic Arthritis ☐ Ankylosing Spondylitis

☐ Psoriatic Arthritis ☐ Plaque Psoriasis

☐ Rheumatoid Arthritis ☐ Hidradenitis Suppurativa

☐ Ulcerative Colitis ☐ Uveitis

☐ Crohn's Disease ☐ Other. Specify : _____

JUVENILE IDIOPATHIC ARTHRITIS

Is the condition moderate or severe? ☐ Moderate ☐ Severe

Will adalimumab be used in combination with methotrexate? ☐ Yes ☐ No

If no, please specify the reasons: ☐ Contraindication ☐ Intolerance ☐ Other. Specify: _____

Please confirm the following pre-treatment data as well as the dates on which they were obtained:

C-reactive protein level Initial assessment: _____ mg/L Date (AAAA/MM/JJ) : _____

Erythrocyte sedimentation rate Initial assessment: _____ mg/L Date (AAAA/MM/JJ) : _____

Number of joints with active synovitis: _____

Following previous treatments, is the disease active? ☐ Yes ☐ No

PSORIATIC ARTHRITIS OR RHEUMATOID ARTHRITIS

☐ Psoriatic arthritis (rheumatoid form) ☐ Psoriatic arthritis (non-rheumatoid form) ☐ Rheumatoid arthritis

☐ Peripheral form ☐ Axial form

Is the condition moderate or severe? ☐ Moderate ☐ Severe

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PSORIATIC ARTHRITIS OR RHEUMATOID ARTHRITIS (CONTINUED)

Please confirm the following pre-treatment data as well as the dates on which they were obtained:

HAQ	Initial assessment: _____	Date (AAAA/MM/JJ) : _____
C-reactive protein level	Initial assessment: _____ mg/L	Date (AAAA/MM/JJ) : _____
CDAI	Initial assessment: _____	Date (AAAA/MM/JJ) : _____
DAS28	Initial assessment: _____	Date (AAAA/MM/JJ) : _____
SDAI	Initial assessment: _____	Date (AAAA/MM/JJ) : _____
BASDAI	Initial assessment: _____	Date (AAAA/MM/JJ) : _____
Erythrocyte sedimentation rate	Initial assessment: _____ mm/h	Date (AAAA/MM/JJ) : _____

Number of joints with active synovitis: _____

Presence of a positive rheumatoid factor? ☐ Yes ☐ No

Presence of radiologic erosions? ☐ Yes ☐ No

ULCERATIVE COLITIS

Is the condition moderate or severe? ☐ Moderate ☐ Severe

Please confirm the following data as well as the dates on which they were obtained:

MAYO	Initial assessment: _____	Date (YYYY/MM/DD) : _____
Endoscopic sub-score	Initial assessment: _____	Date (YYYY/MM/DD) : _____
Rectal bleeding sub-score	Initial assessment: _____	Date (YYYY/MM/DD) : _____
Partial MAYO score	Initial assessment: _____	Date (YYYY/MM/DD) : _____
PUCAI	Initial assessment: _____	Date (YYYY/MM/DD) : _____

Was the medication initiated in the hospital? ☐ Yes ☐ No

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

Will the medication be used in combination with other treatments for ulcerative colitis? ☐ Yes ☐ No

If yes, specify the treatment(s): _____

CROHN'S DISEASE

Is the condition moderate or severe? ☐ Moderate ☐ Severe

For **adult** disease, please confirm the following pre-treatment data as well as the dates on which they were obtained:

CDAI	Initial assessment: _____	Date (YYYY/MM/DD) : _____
HBI	Initial assessment: _____	Date (YYYY/MM/DD) : _____

For **pediatric** disease, please confirm the following pre-treatment data as well as the dates on which they were obtained:

PCDAI	Initial assessment: _____	Date (YYYY/MM/DD) : _____

Has the patient ever been hospitalized? ☐ Yes ☐ No

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

Has the patient been diagnosed with fistulizing Crohn's disease? ☐ Yes ☐ No

Disease location and complications: _____

Has the patient received a trial of intravenous steroids for a minimum of three days during a hospitalization? ☐ Yes ☐ No

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ANKYLOSING SPONDYLITIS

☐ Peripheral form ☐ Axial form

Is the condition moderate or severe? ☐ Moderate ☐ Severe

Please confirm the following pre-treatment data as well as the dates on which they were obtained:

BASDAI Initial assessment: _____ Date (YYYY/MM/DD) : _____

ASDAS Initial assessment: _____ Date (YYYY/MM/DD) : _____

HAQ Initial assessment: _____ Date (YYYY/MM/DD) : _____

BASFI Initial assessment: _____ Date (YYYY/MM/DD) : _____

Does the patient have uveitis? ☐ Yes ☐ No

PLAQUE PSORIASIS

Is the condition moderate or severe? ☐ Moderate ☐ Severe

Please confirm the following pre-treatment data as well as the dates on which they were obtained:

DLQI Initial assessment: _____ Date (YYYY/MM/DD) : _____

PASI Initial assessment: _____ Date (YYYY/MM/DD) : _____

BASFI Initial assessment: _____ Date (YYYY/MM/DD) : _____

BSA Initial assessment: _____ % Date (YYYY/MM/DD) : _____

PLAQUE PSORIASIS (CONTINUED)

Is there significant plaque involvement? ☐ Yes ☐ No

Please specify the affected body areas: ☐ Face ☐ Hands ☐ Feet ☐ Genital ☐ Other. Specify: _____

Has there been a failure of phototherapy treatment? ☐ Yes ☐ No

Number of sessions: _____ Duration of treatment (months): _____

Indicate the reason why phototherapy treatment had to be discontinued: _____

HIDRADENITIS SUPPURATIVA

Is the condition moderate or severe? ☐ Moderate ☐ Severe

Hurley Stage: ☐ I ☐ II ☐ III

Count of abscesses / inflammatory nodules / lesions: _____

Has the patient had an unsatisfactory response to at least three months of oral antibiotic therapy? ☐ Yes ☐ No

Does the patient have lesions in at least two distinct anatomical regions? ☐ Yes ☐ No

UVEITIS

☐ Pediatric uveitis ☐ Adult uveitis

Please confirm the following pre-treatment data as well as the dates on which they were obtained, according to the criteria of the *Standardization of Uveitis Nomenclature Working Group* and the *NEI* criteria:

Anterior chamber cell grade Initial assessment: _____ Date (YYYY/MM/DD) : _____

Anterior chamber haze grade Initial assessment: _____ Date (YYYY/MM/DD) : _____

Please confirm the following pre-treatment data as well as the dates on which they were obtained, according to the *Early Treatment Diabetic Retinopathy Study chart* :

Best corrected visual acuity (BCVA) Initial assessment: _____ Date (YYYY/MM/DD) : _____

Will adalimumab be used in combination with methotrexate? ☐ Yes ☐ No

If no, please specify the reasons: ☐ Contraindication ☐ Intolerance ☐ Other. Specify: _____

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UVEITIS (CONTINUED)

Specify the type of uveitis: ☐ Anterior ☐ Intermediate ☐ Posterior ☐ Panuveitis

The uveitis is: ☐ Infectious ☐ Non-infectious

Is the disease active? ☐ Yes ☐ No

s the disease associated with juvenile idiopathic arthritis? ☐ Yes ☐ No

Is the patient corticosteroid-dependent? ☐ Yes ☐ No

Does the patient have documented history of at least one disease exacerbation within the last 18 months following the initiation of oral corticosteroid therapy?

☐ Yes ☐ No

If yes, indicate whether this exacerbation occurred within 28 days after tapering oral corticosteroids: ☐ Yes ☐ No

Indicate the number of active retinal or chorioretinal vascular inflammatory lesions: _____

SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

PSORIATIC ARTHRITIS OR RHEUMATOID ARTHRITIS

Please confirm the following data as well as the dates on which they were obtained:

HAQ	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
C-reactive protein	Initial assessment : _____ mg/L	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
CDAI	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
ARC	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
Erythrocyte sedimentation rate	Initial assessment : _____ mm/h	Most recent assessment : _____	Date (YYYY/MM/DD) : _____

Number of joints with active synovitis at initial assessment: _____

Number of joints with active synovitis at the most recent assessment: _____ Date (YYYY/MM/DD) : _____

Has the patient returned to work? ☐ Yes ☐ No

If yes, please specify the return-to-work date (YYYY/MM/DD) : _____

ULCERATIVE COLITIS

Please confirm the following data as well as the dates on which they were obtained

MAYO	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
Endoscopic sub-score	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
Rectal bleeding sub-score	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
Partial MAYO score	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____

Has there been an improvement in stool frequency or rectal bleeding? ☐ Yes ☐ No

CROHN'S DISEASE

For **adult** disease, please confirm the following data as well as the dates on which they were obtained:

CDAI	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____
HBI	Initial assessment : _____ mg/L	Most recent assessment : _____	Date (YYYY/MM/DD) : _____

For **pediatric** disease, please confirm the following data as well as the dates on which they were obtained:

PCDAI	Initial assessment : _____	Most recent assessment : _____	Date (YYYY/MM/DD) : _____

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ANKYLOSING SPONDYLITIS

Please confirm the following data as well as the dates on which they were obtained:

BASDAI Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

HAQ Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

BASFI Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

Has the patient returned to work? ☐ Yes ☐ No

If yes, please specify the return-to-work date (YYYY/MM/DD) : _____

PLAQUE PSORIASIS

Please confirm the following data as well as the dates on which they were obtained:

PASI Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

DLQI Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

BSA Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

Significant improvement of body lesions: ☐ Yes ☐ No

HIDRADENITIS SUPPURATIVA

Is there improvement but a sub-optimal response after at least 12 weeks of treatment? ☐ Yes ☐ No

Please indicate the number of abscesses, inflammatory nodules, or lesions: _____

Pre-treatment (YYYY/MM/DD): _____ Recent (YYYY/MM/DD): _____

Increase in fistulas or drainage: ☐ Yes ☐ No

Has the number of abscesses/inflammatory nodules/lesions increased or decreased since the start of treatment? ☐ Increase ☐ Decrease

UVEITIS

☐ Pediatric uveitis ☐ Adult uveitis

Please confirm the following pre-treatment data as well as the dates on which they were obtained, according to the criteria of the *Standardization of Uveitis Nomenclature Working Group* and the *NEI* criteria:

Anterior chamber cell grade Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

Anterior chamber haze grade Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

Please confirm the following pre-treatment data as well as the dates on which they were obtained, according to the *Early Treatment Diabetic Retinopathy Study chart* :

Best corrected visual acuity (BCVA) Initial assessment : _____ Most recent assessment : _____ Date (YYYY/MM/DD) : _____

Has there been improvement or stabilization of vision? ☐ Yes ☐ No

Has there been sustained absence of disease progression? ☐ Yes ☐ No

Has corticosteroid use been tapered or discontinued? ☐ Yes ☐ No

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

Submit a claim through the **members portal** Claim type *Prior authorization drugs*	By mail : AGA Benefit Solutions 3500 de Maisonneuve Blvd. W, suite 2200 Westmount (QC) H3Z 3C1