Equitable™

Specialty Drug Management Program (SDMP)

You have been prescribed a drug that requires approval under the Equitable™ Specialty Drug Management Program (SDMP) in your Group Benefits drug plan. The purpose of this program is to:

- Confirm that the prescribed treatment plan has been approved by Health Canada for your condition; and/or
- Verify the cost effectiveness of your prescribed treatment plan.

Next Steps

1 **Complete the SDMP Reimbursement Request Form**
Complete Section A of the attached form. Have your Physician complete Section B.

2 **Submit the SDMP Reimbursement Request Form**
Submit your completed form to TELUS Health (Equitable's pharmacy benefits manager) for evaluation.

Within five business days* of receiving your completed form, TELUS Health will notify you about whether your drug will be covered under your group benefits plan.

3 **Fill your prescription**
If your claim is approved you can proceed with having your prescription filled.

Residents of British Columbia, Saskatchewan, Manitoba or Ontario:

Your drug may be eligible for coverage under your provincial public drug program (British Columbia: Pharmacare Special Authority; Manitoba/Saskatchewan: Exception Drug Status Program; Ontario: Seniors ODB Limited Use and Exceptional Access Program).

If your drug is eligible to be considered for coverage under your Equitable plan, you must first apply for provincial coverage and, where applicable, provide us with the decision letter from the provincial program. For some drugs, you will be required to provide a decision letter before coverage under the Equitable benefits plan will begin.

**Response times will vary if your claim requires providing Equitable a copy of your provincial pharmacare decision letter. In such cases Equitable will notify you of your coverage eligibility.*

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SPECIALTY DRUG MANAGEMENT PROGRAM REIMBURSEMENT REQUEST FORM

For biologic response modifier: Entyvio (vedolizumab)

A. INFORMATION TO BE COMPLETED BY PATIENT

Employee or Insured's Name: _____

Policy No: _____ Certificate No: _____

Patient Name: _____

Patient Province of Residence: _____ Birthday (dd/mm/yyyy): _____

Relationship with Employee: ☐ Self ☐ Spouse ☐ Dependant

Does your plan have a pay direct drug card ☐ Yes ☐ No

Patient/Parent/Legal guardian phone number: _____

Patient/Parent/Legal guardian email address: _____

CONTACT INFORMATION FOR NOTIFICATION OF RESULTS:

☐ Contact me	☐ Contact my reimbursement request representative (e.g. patient support program, physician, pharmacy, caregiver) Name: _____
☐ By e-mail:	☐ By phone (and leave a message if I'm not there):

I certify that the information provided by me on this form (the "Information") is true, correct, and complete to the best of my knowledge. The Information is willingly provided by me to The Equitable Life Insurance Company of Canada ("Equitable"). I acknowledge that the Information will be held in Equitable's files and will be used for the purposes of underwriting, policy administration, claims processing, and claims investigation. I understand and authorize that, for the above purposes and only to the extent necessary, the Information on file may be used by, accessible to, and exchanged with Equitable; authorized employees and representatives of Equitable; relevant third parties retained by Equitable, including but not limited to TELUS Health; any industry drug pooling entity; participating reinsurer(s); other insurance companies; health care providers including but not limited to pharmacies, physicians, dentists, and practitioners; medical suppliers; government, regulatory, and investigative organizations; my Plan Sponsor; and any other party whom I authorize or as required by law. For the above-referenced purposes, I authorize any health care provider, medical facility, pharmacy, and any other party that has any relevant information/record/knowledge of me or my health to give Equitable and/or TELUS Health (a service provider of Equitable) full particulars of such information, including any prior medical history and benefit.

Signature of Patient/Parent/Legal guardian: _____ Date (dd/mm/yyyy): _____

B. INFORMATION TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Entyvio (vedolizumab) will be eligible for reimbursement only if the patient satisfies one of the conditions listed below, AND has failed an adequate trial of the corresponding treatment of choice as indicated on the form. The treatment of choice may also be subject to prior authorization. Failure of the treatment of choice is defined as a serious side effect, contraindication, and/or an ineffective response. Coverage will then be considered only if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.

The most current version of this form supersedes all prior versions. The form may be modified without notice to you and we reserve the right to accept only the current version.

Equitable™ TELUS | HEALTH™

SPECIALTY DRUG MANAGEMENT PROGRAM REIMBURSEMENT REQUEST FORM
For biologic response modifier: Entyvio (vedolizumab)

Policy No: _____ Certificate No: _____

B. INFORMATION TO BE COMPLETED BY PRESCRIBING PHYSICIAN (CONTINUED)

Please indicate if the patient satisfies the following criteria:

☐ **Crohn's Disease:**
The patient:
- ☐ Is ≥ 18 years of age; **AND**
- ☐ Has a diagnosis of moderately to severely active Crohn's Disease (Crohn's Disease Activity Index [CDAI] score of 220 to 450); **AND**
- ☐ Has Crohn's Disease involvement of the ileum and/or colon; **AND**
- ☐ Has tried and failed conventional immunomodulators **OR** corticosteroids; **AND**
- ☐ Has tried and failed either adalimumab **OR** infliximab; **AND**
- ☐ Does not have extensive colonic resection, subtotal or total colectomy; **AND**
- ☐ Does not have an ileostomy, colostomy or known fixed symptomatic stenosis of the intestine; **AND**
- ☐ Physician is a gastroenterologist or is experienced in the management of Crohn's Disease

OR

☐ **Ulcerative Colitis:**
☐ ***Initial Criteria (Approval period of 16 weeks):***
The patient:
- ☐ Is ≥ 18 years of age; **AND**
- ☐ Has a diagnosis moderately to severely active ulcerative colitis (Mayo score 6 to 12 with endoscopic sub-score ≥2); **AND**
- ☐ Has had an inadequate response, loss of response, or was intolerant to conventional therapy (corticosteroid and/or aminosalicylate and/or immunosuppressant); **AND**
- ☐ Has had an inadequate response, loss of response, contraindication, or was intolerant to a TNF inhibitor biosimilar agent
- ☐ Physician is a gastroenterologist or is experienced in the management of ulcerative colitis

☐ ***Renewal Criteria (approval period of 1 year):***
Patient has exhibited:
- ☐ a decrease in the Mayo score of at least 3 points and at least 30 %, or a decrease in the partial Mayo score of at least 2 points; **AND**
- ☐ a Mayo rectal bleeding subscore of 0 or 1 point, or a decrease in this subscore of at least 1 point.

OR

☐ None of the above applies

☐ Relevant additional information _____

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SPECIALTY DRUG MANAGEMENT PROGRAM REIMBURSEMENT REQUEST FORM

For biologic response modifier: Entyvio (vedolizumab)

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B. INFORMATION TO BE COMPLETED BY PRESCRIBING PHYSICIAN (CONTINUED)

When was the patient first diagnosed with this condition? (dd/mm/yyyy) _____

When did treatment begin for this condition? (dd/mm/yyyy) _____

If the patient resides in BC, SK, MB, or ON, the drug may be eligible for coverage under the provincial public drug program (e.g. Pharmacare Special Authority, Exceptional Drug Program, Seniors ODB EAP). Coverage under the provincial drug program must be pursued before the drug will be considered for eligibility under the Equitable Life plan.

Has a submission been made to a provincial public drug program? ☐ Yes ☐ No

Physician's Name: _____

License Number: _____ Phone Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Physician's Signature: _____ Date (dd/mm/yyyy): _____

C. FORM SUBMISSION

Send completed form by Fax to:	**TELUS Health** **Attn.: Pharmacy Services** Fax: 1-866-840-1509	Allow five business days for a response once complete information is received by TELUS Health. Notification of the results will occur from Mon – Fri between 9 am – 4 pm ET.

Contact Equitable Life if you have any questions about the Program, the form, the reimbursement decision, or to inquire on the status of your Reimbursement Request Form. The cost, if any, of completing this form is at the expense of the patient/ Plan Member.

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