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.*

BioScript PHARMACIE·PHARMACY

Fill your prescription at BioScript for cost savings and best-in-class patient care

Equitable has partnered with BioScript, one of Canada's leading pharmacies focused on specialty drugs, to help minimize your out-of-pocket costs while providing best-in-class patient support.
Prescriptions for specialty drugs included in our Specialty Drug Management Program will only be eligible for coverage when filled at a BioScript pharmacy*, when Equitable is the primary insurer.

**Preferred Pharmacy Networks do not apply to Quebec residents due to provincial drug legislation.*

Call to fill your prescription or make an appointment.

1 888 569 4131

1409 (2023/11/17)

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SPECIALTY DRUG MANAGEMENT PROGRAM REIMBURSEMENT REQUEST FORM

For biologic response modifiers: etanercept biosimilars (Brenzys, Erelzi)

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

Brenzys, Erelzi (etanercept) 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.

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

Please indicate which etanercept biosimilar is being prescribed:
- ☐ Erelzi
- ☐ Brenzys

Please indicate if the patient satisfies the following criteria:

☐ **Rheumatoid Arthritis (RA)**
The patient:
- ☐ Is ≥ 18 years of age; **AND**
- ☐ Has a diagnosis of moderately to severely active RA; **AND**
- ☐ Has had a diagnosis for ≥ 3 months; **AND**
- ☐ Has tried and failed a minimum 12-week trial of methotrexate plus one other disease modifying anti-rheumatic drug (DMARD). When combinations of non-biologic DMARDs are impossible (a rare situation), 3 consecutive non-biologic DMARDs would be acceptable; **AND**
- ☐ The physician is a rheumatologist or is experienced in the management of RA,

OR

☐ **Juvenile Idiopathic Arthritis (JIA)**
The patient:
- ☐ Is 4 to 17 years of age; **AND**
  - ☐ Weighs 63kgs or more; **AND**
- ☐ Has moderately to severely active polyarticular juvenile idiopathic arthritis, defined as having ≥ 5 active joints and ≥ 3 with limitation of motion, for ≥ 6 months duration; **AND**
- ☐ Has tried and responded inadequately to, is intolerant to, or has contraindications to conventional therapy, including:
  - ☐ At least 1 non-steroidal anti-inflammatory drug (NSAID) at the maximum tolerated dose for a period of at least 4 weeks; **AND**
  - ☐ Methotrexate at the maximum tolerated dose for at least 3 months; **OR**
    - ☐ Another DMARD, including but not limited to sulfasalazine, for a minimum of 3 months if intolerant or has contraindications to methotrexate; **AND**
- ☐ Will be on combination therapy with methotrexate, or etanercept monotherapy if intolerant or has contraindications to methotrexate; **AND**
- ☐ The physician is a rheumatologist or is experienced in the management of juvenile idiopathic arthritis

OR

☐ **Ankylosing spondylitis (AS)**
- ☐ ***Initial criteria (approval period of 1 year):***
  The patient:
  - ☐ Is ≥ 18 years of age; **AND**
  - ☐ Has a clinical diagnosis of ankylosing spondylitis that meets the modified New York criteria for ankylosing spondylitis; **AND**

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

- ☐ Has active ankylosing spondylitis despite conventional therapy, meeting the following criteria:
  - ☐ A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale for at least 4 weeks while on standard therapy; **AND**
  - ☐ A Spinal pain ≥ 4 on a 0 to 10 Numerical Rating Scale (NRS); **AND**
- ☐ Has tried and failed, or is intolerant to conventional therapy including:
  - ☐ At least 2 non-steroidal anti-inflammatory drugs (NSAIDs), at the maximal/optimal doses for a period of at least 4 weeks each; **AND**
  - ☐ Disease modifying anti-rheumatic drug (DMARD) therapy, including methotrexate up to 25 mg weekly or sulfasalazine up to 3 grams per day, if tolerated, over a period of at least 3 months (for predominantly peripheral disease); **AND**
- ☐ The physician is a rheumatologist or is experienced in the management of ankylosing spondylitis

☐ ***Renewal criteria (approval period of 1 year):***
The patient has achieved at least 20% improvement from baseline in the Assessment of Spondylo Arthritis International Society (ASAS 20), defined as:
- ☐ Improvement of ≥ 20% **AND** an absolute improvement from baseline of ≥ 2 units on a scale of 0 to 10 in ≥ 3 of the 4 domains; **AND**
- ☐ No worsening by > 20% and > 1 unit in the remaining fourth domain on a scale of 10

Four domains:

1. *Patient's global assessment of disease activity, measured on a numeric rating scale (NRS) from 0 (no activity) to 10 (severe activity);*
2. *Total back pain defined on a NRS from 0 to 10*
3. *Physical function, measured by the Bath Ankylosing Spondylitis Functional Index (BASFI) which consists of 10 items assessing participants' ability to perform activities on an NRS ranging from 0 (easy) to 10 (impossible)*
4. *Inflammation, measured by the mean of the 2 morning stiffness-related Bath AS Disease Activity Index (BASDAI) NRS scores (items 5 [level of stiffness] and 6 [duration of stiffness]) on a scale from 0 to 10*

OR

☐ **Psoriatic Arthritis (PsA)**
The patient:
- ☐ Is ≥ 18 years of age; **AND**
- ☐ Has a diagnosis of PsA with at least 3 swollen and 3 tender joints; **AND**
- ☐ Has plaque psoriasis with a qualifying target lesion ≥ 2 cm in diameter; **AND**
- ☐ Has tried and failed one or more disease-modifying anti-rheumatic drugs (DMARDs); **AND**
- ☐ The physician is a rheumatologist or is experienced in the management of PsA

OR

☐ **Chronic plaque psoriasis (PsO)**
The patient:
- ☐ Is ≥ 18 years of age; **OR**
  - ☐ Is between the ages of 4 and 17 years; **AND**
  - ☐ weighs 63 kg or more; **AND**

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

- ☐ Has ≥ 10% Body Surface Area (BSA) involvement; **OR**
  - ☐ significant involvement of the face, hands, feet or genital regions; **AND**
- ☐ Has a PASI score ≥ 12; **OR**
  - ☐ significant involvement of the face, hands, feet or genital regions; **AND**
- ☐ Has failed to respond, is intolerant to, or unable to access UV phototherapy; **AND**
- ☐ Has failed to respond, or has experienced a specific intolerance to, topical therapy and at least one systemic therapy; **AND**
- ☐ The prescribing physician is a dermatologist or is experienced in the management of moderate-severe plaque psoriasis

OR

☐ None of the above applies

☐ Relevant additional information _____

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): _____

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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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