

## Step Therapy Program

Certain prescription drugs call for a more detailed assessment to help ensure that they represent reasonable treatment. For these drugs, Great-West's Special Authorization program generally requires that you request approval from Great-West Life for coverage of certain prescription drugs. As part of the Special Authorization program, we may ask that you and your physician provide additional information, including information to help us determine whether: (i) there are other drugs that may be tried first to treat your medical condition; or (ii) there are lower cost drugs available that are considered to be a reasonable treatment for your medical condition (each a "prerequisite drug").

However, as part of the **Step Therapy** program, additional information will not be required for certain Special Authorization drugs where you have previously received reimbursement for certain prerequisite drugs. The Special Authorization drugs that are currently part of the Step Therapy program are listed in the following table, along with the prerequisite drug(s) for each.

If you have been prescribed:

- (i) a Special Authorization drug that is not part of the Step Therapy program, or
  - (ii) a drug that is part of the Step Therapy program, however your physician feels there are medical reasons to support why a prerequisite drug(s) is not an option for your situation,
- please complete a **Request for Special Authorization** form with your prescribing doctor and submit the form to Great-West Life for consideration.

**Please note:** The information contained in this document is for informational purposes only and is subject to change at any time. Coverage for any prescription drug listed in the following table will depend on the terms of your group benefit plan. In the event of any inconsistency between the information provided here and the terms of your group benefit plan, coverage will be based on the terms of your group benefit plan.

Category	Step Therapy Drug	Prerequisite drug(s) or type of drug
ASTHMA	Accolate (zafirlukast)	An inhaled corticosteroid (e.g. Flovent, Pulmicort, etc.) AND a short acting beta <sub>2</sub> -agonist (e.g. salbutamol)
ASTHMA	Singulair (montelukast)	An inhaled corticosteroid (e.g. Flovent, Pulmicort, etc.) AND a short acting beta <sub>2</sub> -agonist (e.g. salbutamol)
BENIGN PROSTATIC HYPERPLASIA	Avodart (dutasteride)	An alpha-blocker (e.g. tamsulosin, doxazosin) AND finasteride (Proscar <sup>†</sup> )
BENIGN PROSTATIC HYPERPLASIA	Proscar (finasteride)	An alpha-blocker (e.g. tamsulosin, doxazosin, etc.)
BLADDER DISORDERS	Detrol LA (tolterodine)	Immediate-release oxybutynin
BLADDER DISORDERS	Ditropan XL (oxybutynin)	Immediate-release oxybutynin
BLADDER DISORDERS	Enablex (darifenacin)	Immediate-release oxybutynin
BLADDER DISORDERS	Toviaz (fesoterodine)	Immediate-release oxybutynin
BLADDER DISORDERS	Trosec (trospium)	Immediate-release oxybutynin
BLADDER DISORDERS	Vesicare (solifenacin)	Immediate-release oxybutynin
CHOLESTEROL DISORDERS	Ezetrol (ezetimibe)	A statin (e.g. atorvastatin, simvastatin, rosuvastatin, pravastatin, lovastatin, fluvastatin, etc.)
CHRONIC PULMONARY RESPIRATORY DISEASE (COPD)	Duovent (fenoterol/ipratropium)	Combivent (e.g. ipratropium/salbutamol)
DEPRESSION	Wellbutrin (bupropion)	At least one other antidepressant drug (e.g. paroxetine, mirtazapine, venlafaxine, etc.)
DIABETES	Janumet (sitagliptin/metformin)	A biguanide (e.g. metformin) AND a sulfonylurea (e.g. glyburide, gliclazide) AND Januvia
DIABETES	Januvia (sitagliptin)	A biguanide (e.g. metformin) AND a sulfonylurea (e.g. glyburide, gliclazide)
DIABETES	Jentaduetto (linagliptin/metformin)	A biguanide (e.g. metformin) AND a sulfonylurea (e.g. glyburide, gliclazide) AND Trajenta
DIABETES	Trajenta (linagliptin)	A biguanide (e.g. metformin) AND a sulfonylurea (e.g. glyburide, gliclazide, etc.)
EPILEPSY	Fycompa (perampanel)	At least two other anti-epileptic drugs (e.g. phenytoin, carbamazepine, primidone, valproic acid, divalproex, lamotrigine, topiramate*, etc.)
EPILEPSY	Keppra (levetiracetam)	At least one other anti-epileptic drug (e.g. phenytoin, carbamazepine, primidone, valproic acid, divalproex, lamotrigine, topiramate*, etc.)
EPILEPSY	Trileptal (oxcarbazepine)	At least three anti-epileptic drugs (e.g. phenytoin, carbamazepine, primidone, valproic acid, divalproex, lamotrigine, topiramate*, etc.)
EPILEPSY	Vimpat (lacosamide)	At least two other anti-epileptic drugs (e.g. phenytoin, carbamazepine, primidone, valproic acid, divalproex, lamotrigine, topiramate*, etc.)
HORMONE	Visanne (dienogest)	Another hormonal agent (e.g. Ortho 7-7-7, Tricyclen, Marvelon, etc.)
MENTAL HEALTH	Zeldox (ziprasidone)	At least one other antipsychotic drug (e.g. olanzapine, risperidone, quetiapine, etc.)
MIGRAINES	Imitrex injection (sumatriptan)	An oral triptan drug (e.g. sumatriptan, rizatriptan, etc.) and a nasal triptan drug (e.g. sumatriptan ‡, zolmitriptan ‡)
MIGRAINES	Imitrex nasal spray (sumatriptan)	At least one oral triptan drug first (e.g. sumatriptan, rizatriptan, etc.)
MIGRAINES	Zomig nasal spray (zolmitriptan)	At least one oral triptan drug first (e.g. sumatriptan, rizatriptan, etc.)
NEUROPATHIC PAIN	Cymbalta (duloxetine)	At least two other drugs for the treatment of neuropathic pain (e.g. nortriptyline, amitriptyline, gabapentin*, pregabalin*, etc.)
OSTEOPOROSIS	Evista (raloxifene)	At least one bisphosphonate (e.g. alendronate, risedronate, etc.)
SKIN DISORDERS	Ultravate (halobetasol)	A high-potency topical steroid (e.g. Dermovate, Topicort, Lyderm, Betaderm, etc.)

\*Prerequisite drugs that are under the Special Authorization program. A **Request for Special Authorization** form must be completed by the prescribing physician and submitted to Great-West Life for review.

‡ Prerequisite drugs that are also under the Step Therapy program.

## Request for Special Authorization

Certain prescription drugs call for a more detailed assessment to help ensure that they represent reasonable treatment. Special Authorization requires that you request approval from Great-West Life for coverage of certain prescription drugs.

In order for your claim to be considered, additional information from you and your physician is needed to help us determine whether:

- there are other medications that may be tried first to treat your medical condition; and
- coverage is available for the prescribed drug under other programs.

If approved, the effective date of coverage will be the date coverage was approved by Great-West Life. Requests for coverage prior to the approval date will be considered on an exception basis only.

Special Authorization may be limited to a specified time period and/or quantity of medication. Renewal of the Special Authorization will be considered upon request from the plan member. The renewal request should include information from the physician supporting continued use of the medication.

### Form Completion Instructions:

1. **Print this information sheet and the attached Special Authorization form;**
2. **Complete Part 1 and Part 2 of the form;**
3. **Have your physician complete Part 3 of the form;**
4. **Send the completed Request for Special Authorization form to us by mail or fax to the address or fax number noted below and at the end of the form.**

### Acknowledgements

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), refer to [www.greatwestlife.com](http://www.greatwestlife.com) or write to Great-West Life's Chief Compliance Officer.

I authorize Great-West Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient assistance programs or other benefits programs, other organizations, or service providers working with Great-West Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing my consent will help Great-West Life to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

### **Please have Part 3 completed by your prescribing physician.**

Mail to: The Great-West Life Assurance Company  
Drug Services  
PO Box 6000  
Winnipeg MB R3C 3A5

Fax to: The Great-West Life Assurance Company  
Fax 1-204-946-7664  
Attention: Drug Services

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## Request for Special Authorization

The purpose of this form is to obtain information required to assess your drug claim. To be eligible for coverage, the drug must represent reasonable treatment of the disease or injury upon which your claim is based. Approval for coverage of this drug may be reassessed at any time at Great-West Life's discretion.

**IMPORTANT:** Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

**Any costs incurred for the completion of this form are the responsibility of the plan member/patient.**

*Please print*

Part 1 Plan Member Information	
Plan Member:	Patient Name:
Plan Number: <input type="checkbox"/> 168000 <input type="checkbox"/> 168074	Plan Member Identification Number:
Patient Date of Birth (DD/MM/YYYY):	Address (number, street, city, province, postal code):
Part 2 Coordination of Benefits	
Are you currently on, or have you previously been on this drug? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, a) indicate start date: (DD/MM/YYYY) _____	
b) coverage provided by: _____	
(if coverage is not provided by Great-West Life please provide a Pharmacy print out showing purchase of this drug).	
Have you applied for coverage or received any financial assistance or other support related to this drug:	
Under any group benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of covered family member: _____ Relationship: _____ Name of Insurance Company: _____ Plan number: _____ Plan Member I.D. number: _____ <b>Provide details and attach documentation of acceptance or declination:</b> _____
Under a provincial program or from any other source? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of program or other source: _____ <b>Provide details and attach documentation of acceptance or declination:</b> _____
	If No, please explain why application has not been made: _____
Under a patient assistance program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of program(s): _____ Patient assistance program I.D. number: _____ Patient assistance program contact person name and phone number: Contact name: _____ Phone number: (_____) _____
Are you currently receiving disability benefits for the condition for which this drug has been prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>I acknowledge/declare that the information I have provided on this form is true, correct, and complete to the best of my knowledge.</b>	
<b>Patient/Guardian's signature:</b> _____ <b>Date:</b> _____	

(Continued on next page)

## Request for Special Authorization

Attach extra information if necessary.

**Part 3 Physician Information (to be completed for all conditions for which the drug has been prescribed).**  
**Note to Physician:** In order to assess a patient's claim for this drug, we require detailed information on the patient's prescription drug history requested below.

**TO BE COMPLETED BY PHYSICIAN**

Physician Name:	Specialty:
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Telephone Number (including area code):	Fax Number (including area code):	Registration number:
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Address:

**DRUG REQUESTED FOR SPECIAL AUTHORIZATION**

Drug Name:	Dosage:	Duration:
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Patient Diagnosis (include date of initial diagnosis) (MM/YYYY):

Previous Medication Trial	Dosing Regimen	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Patient response to treatment (if discontinued, provide details of intolerance, contraindication, or failure at maximum dose)

**REASON FOR REQUEST**

contraindication   
  therapeutic failure   
  adverse event  
 Other (provide details): \_\_\_\_\_

**DIAGNOSTIC TESTING**

Diagnosis confirmed via: \_\_\_\_\_ Date (MM/YYYY): \_\_\_\_\_

**OTHER COMMENTS:**

**I certify that the information provided on this Part 3 is true, correct and complete.**

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. The completed Request for Special Authorization form can be returned to Great-West Life by mail or fax.

Mail to: The Great-West Life Assurance Company Drug Services PO Box 6000 Winnipeg MB R3C 3A5	Fax to: The Great-West Life Assurance Company Fax 1-204-946-7664 Attention: Drug Services
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