IUOE Local 793

Pension and Benefits Administered by OEBAC

Prior Authorization for Actemra® (Tocilizumab)

A Introduction

Plan Members need this form to initiate a pre-authorization process for the IUOE Local 793 Plan to cover the use of this drug.

➔ Expenses incurred by the completion of this form are at the Plan Member's expense.

➔ If the patient has another drug plan, this prior authorization may cover some or all the excess not paid for by that plan.

Please request, fill in, and return an updated Personal Information File (PIF) to notify OEBAC of any changes in information about: **(a)** you, the Plan Member; **(b)** your dependants; **(c)** any other health care plan that you or your dependants may have; **(d)** your beneficiaries; **(e)** your bank accounts; or **(f)** the individuals authorized to inquire about your benefits. By doing this on time, you will facilitate faster processing of your claims and reduce the chances of claim rejection.

B To be completed by Plan Member

For office use only
ABCDEFGH

Full Name		From your OEBAC Benefits Card Group #: ☐ 793 ☐ 793X Certificate #:
Phone #	Email	Or, from your IUOE Local 793 Card Registration #:

Patient's Name	Results of this request to be communicated to: ☐ Pharmacy ☐ Patient / Legal guardian named below ☐ Email:
Phone #	

Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian	Date (yyyy-mm-dd)

By signing below,

- I solemnly declare that the information provided on this form is accurate to the best of my knowledge.
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use and disclose the provided information and any other information collected about me, my Dependants, or my Beneficiaries to process my benefits, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans.

Name of the Plan Member	Signature of the Plan Member	Date (yyyy-mm-dd)

C To be completed by Prescribing Physician or Pharmacist

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Drug Name	DIN
Actemra® (Tocilizumab)	**02350114 02350106 02350092 02424770**
Concentration	Dosage

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- ☐ To reduce the signs of moderate to severe active rheumatoid arthritis in adult patients.
- ☐ To treat active systemic juvenile idiopathic arthritis in children aged 2 years or older who have responded inadequately with previous therapy of one or more non-steroidal anti-inflammatory drugs and systemic corticosteroids.
- ☐ To treat signs and symptoms of active polyarticular juvenile idiopathic arthritis in children aged 2 years or older who have responded inadequately with previous therapy of one or more non-steroidal anti-inflammatory drugs and systemic corticosteroids.
- ☐ To treat giant cell arteritis (GCA) in adults-subcutaneous formulation only.

Physician's Name	Licence Number	Phone #	Fax Number
Address	Town/City	Province	Postal Code

Name of Physician or Pharmacist	Signature of Physician or Pharmacist	Date (yyyy-mm-dd)

D To be completed by Pharmacist

For office use only
ABCDEFGH

Pharmacy Name	Provider Number	Telephone Number	Fax Number
Pharmacy Address	Town/City	Province	Postal Code

Name of Pharmacist	Signature of Pharmacist	Date (yyyy-mm-dd)

Staple this form and all the attachments and mail them to

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to

info@oebac.org