THE Great-West Life ASSURANCE COMPANY

Request for Information: Thyrogen (thyrotropin alfa)

The purpose of this form is to obtain information required to assess your claim for the above drug. For the coverage to apply, the drug must represent reasonable treatment of the disease or injury upon which your claim is based. If treatment continues after a one-year period, you may be asked to reapply and provide information that demonstrates the effectiveness of the drug.

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

Please complete the following:

Plan Member (please print)	Patient Name (please print)
Plan Name	Plan Number
I.D. Number	Date of Birth (day, month, year)

Address (number, street, city, province, postal code)

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.

I authorize Great-West Life, my physician or healthcare provider, the plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes.

Patient's signature: _____

Please have the following completed by your prescribing physician:

Name of attending physician (please print)	Specialty

Address (number, street, city, province, postal code)

Telephone Number (including area code)	Fax Number (including area code)

1. **Please provide details of thyroid cancer:**
   Staging: _____
   Cell Type: _____
   Extent of spread beyond thyroid capsule: _____
   ☐ Local Invasion ☐ Nodes ☐ Distant metastases
2. **Date(s) of surgery:**
   Complete thyroidectomy: _____
   Partial thyroidectomy: _____
   Date of I-131 treatment: _____
3. **Current request for thyrogen:**
   ☐ To maximize I-131 treatment ☐ For diagnosis of residual thyroid tissue
4. **Provide details of prior use of thyrogen for surveillance: (add list of applicable):**
   Dates: _____
   Results: _____
   Dates: _____
   Results: _____
5. **Provide date(s) of proposed repeat testing:**
   Dates: _____

Physician's signature: _____ Date: _____

It is important to provide the requested information in detail to avoid delay in assessing claims for the above drug. The completed Request for Information form can be returned to Great-West Life at the address or fax number below.

Mail to: The Great-West Life Assurance Company
Drug Services, P.O. Box 6000
Winnipeg, Manitoba R3C 3A5

Fax to: The Great-West Life Assurance Company
Fax Number: 1.204.946.7664
Attention: Drug Services