# Exception Request Form
## Mandatory Biosimilar Transition Exception

**IMPORTANT:** All correspondence concerning this form will be sent to the address indicated in the participant's file.
Send us this duly completed form by mail or by fax to: **1-855-453-3942**.
Telephone: 418-651-2588/1-800-380-2588 • Fax: 1-855-453-3942
Address: 2525 Laurier Blvd, P.O. Box 10500, Quebec City, QC G1V 4H6

## DECLARATION OF THE INSURED PERSON

### 1. Information about the plan member and the patient

Name of Plan Member

Insurance Policy / Certificate

Name of Employer

Name of Patient

Date of Birth (Y Y Y Y M M D D)

Telephone

Address (house number and street name)

City/Town

Province

Postal Code

### 2. Other prescription drug insurance policies

Do you have other prescription drug insurance? ☐ Yes ☐ No

If so, please answer the following:

- What type of plan is it? ☐ Private ☐ Public
- Have you ever submitted a claim for this drug to the other insurer? ☐ Yes ☐ No
  - What is the status of the claim? ☐ Accepted ☐ Refused ☐ Under review
- Did this insurer ask you to complete a prior authorization request? ☐ Yes ☐ No
  - If so, what is the status of the prior authorization request? ☐ Accepted ☐ Refused ☐ Under review

**Please enclose acceptance or refusal documents, if applicable**

### 3. Authorization to disclose personal information

I certify that the information in this prior authorization request is complete, accurate and true.

I authorize physicians and other health care professionals, medical, paramedical or clinical institutions, care coordinators, members of SSQ's Preferred Pharmacy Network (outside Quebec only) and any public or parapublic organization, including Régie de l 'assurance maladie du Québec, to disclose to SSQ, Life Insurance Company Inc. (SSQ) any of my personal information including and without limitation, any relevant medical information and medical evaluations in connection with the processing of this request. I hereby waive their confidentiality obligation and authorize them to disclose the requested information to SSQ. In addition, I authorize SSQ to disclose to the previously named third parties any of my relevant personal information including and without limitation any medical information and medical evaluations in connection with the processing of this request.

Photocopies of this document have the same value as the original.

**X** _____ (Y Y Y Y M M D D)

Signature of patient (parent/legal guardian) Date

## DECLARATION OF THE PHYSICIAN

### 4. Information about the prescribing physician

**Name of physician**

Specialty

Licence No.

Telephone

Fax

I hereby certify that the information in this request is complete, true and accurate:

**X** _____ (Y Y Y Y M M D D)

**Signature of physician** Date



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## 5. Drug covered by the authorization

Name of drug | Pharmaceutical form | Strength

Specify indication: _____

**IMPORTANT** For insureds covered in coordination under a primary public provincial drug plan:

**The provincial drug plan's exceptions to biosimilar transition are applicable and will be upheld. Please submit exceptin request to your primary provincial drug plan and forward the response to SSQ Insurance along with this form.**

Patients NOT covered under a provincial drug plan: Specify the medical reason prohibiting the safe transition to a biosimilar version of the targeted drug*:

☐ Current pregnancy, specify expected due date: Y Y Y Y M M D D

☐ Therapeutic failure (≥2) to other biologic drugs used to treat the same indication, specify:

_____ From Y Y Y Y M M D D until Y Y Y Y M M D D
Biologic drug — Treatment period

_____ From Y Y Y Y M M D D until Y Y Y Y M M D D
Biologic drug — Dates d'utilisation

_____ From Y Y Y Y M M D D until Y Y Y Y M M D D
Biologic drug — Dates d'utilisation

☐ The insulin pump used to administer this drug is not compatible with its equivalent biosimilar version, specify : _____

_____

☐ Other reason, specify: _____

* For patients covered in coordination another primary private drug plan, please provide proof or authorization or reimbursement of your drug by this plan, along with this form.



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