PRIOR AUTHORIZATION REQUEST FORM
Palbociclib (Ibrance®) / Advanced or metastatic breast cancer

DECLARATION OF THE INSURED PERSON

Section 1 : Information about the plan member and the patient			
Name of plan member	Policy Certificate	Name of employer:	
Name of patient	Date of birth (YYYY/MM/DD)	Telephone	
Address (number and street name)	Town/City	Province	Postal code

Section 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

Section 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 relevant personal information including and without limitation, any 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.

_____ YYYY-MM-DD

Signature of **patient** (parent/legal guardian) Date

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

ssq.ca

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DECLARATION OF THE PRESCRIBER

Section 4 : Information about the prescriber		
Name of prescriber	Specialty	License no.
Telephone	Fax	

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

_____ YYYY-MM-DD

Signature of **prescriber** Date

Section 5 : Drug covered by the authorization			
Drug name	**Pharmaceutical form**	**Strength**	**Dosage**
			Dose: _____ Frequency of administration: _____
Type of request	❒ First request Complete section 6		❒ Continuation of treatment Complete section 7 Also complete section 6 if this is the first authorization requested from SSQ

IMPORTANT:
Please do not provide any genetic test results

Section 6 : Clinical information (first request)

Diagnosis

❒ Advanced or metastatic breast cancer in compliance with Health Canada approved indication

For informational purposes only :

IBRANCE (palbociclib) is indicated for the treatment of patients with hormone receptor (HR+) positive, human epidermal growth factor receptor 2 (HER2) negative locally advanced or metastatic breast cancer in combination with:

- *an aromatase inhibitor as initial endocrine-based therapy in post-menopausal women or men;*
- *fulvestrant in patients with disease progression after prior endocrine therapy. Pre- or perimenopausal women must also be treated with a luteinizing hormone releasing hormone (LHRH) agonist.*

❒ Other, specify: _____

Section 6 : Clinical information (first request) (cont'd)

Complete the following information

❒ Post-menopausal ❒ Pre-menopausal

Presence of brain cerebral metastases? ❒ Yes ❒ No

Actual value of the ECOG performance status
❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4

Administration of Ibrance®

Administered as first-line metastatic treatment? ❒ Yes ❒ No

❒ In conjunction with Letrozole
❒ In conjunction with Fulvestrant
❒ In conjunction with Fulvestrant and an LHRH antagonist
❒ Other. Specify: ______________________________

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Name: ____________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: __________	from YYYY-MM-DD To YYYY-MM-DD
Name: ____________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: __________	from YYYY-MM-DD to YYYY-MM-DD
Name: ____________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: __________	from YYYY-MM-DD to YYYY-MM-DD
Name: ____________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: __________	from YYYY-MM-DD to YYYY-MM-DD
Name: ____________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: __________	from YYYY-MM-DD to YYYY-MM-DD

Section 7 : Clinical information (continuation of treatment)

Information necessary to evaluate the response to treatment

The drug covered by the present authorization request was first taken on: YYYY-MM-DD

Positive clinical effects observed

Date treatment began: YYYY-MM-DD

❒ Absence of disease progression

❒ Other, specify: _____

Actual value of the ECOG performance status

❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4

Section 8 : Additional information