PRIOR AUTHORIZATION REQUEST FORM
Tolvaptan (Jinarc®) / Polycystic kidney disease

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**
Jinarc®	Tablets		**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 ❒ Polycystic kidney disease in compliance with Health Canada approved indication For informational purposes only: JINARC (tolvaptan) is indicated to slow the progression of kidney enlargement and kidney function decline in patients with autosomal dominant polycystic kidney disease (ADPKD). ❒ Other, specify: _____

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

Provide the following information:

A. Total kidney volume: _____ml

B. Creatinine clearance: _____ml/min ***OR***

Estimated glomerular filtration rate (eGFR): _____ml/min/1.73 m^2

C. Hypertension ❒ Yes ❒ No

D. Albuminuria ❒ Yes ❒ No

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 effects observed

❒ Benefits in total kidney volume

Kidney volume before the introduction of Jinarc :_____ ml Date: YYYY-MM-DD

Current kidney volume:_____ ml Date: YYYY-MM-DD

❒ Kidney function benefits

Evaluation before the introduction of Jinarc Date: YYYY-MM-DD

Creatinine clearance: _____ml/min **or**

Estimated glomerular filtration rate (eGFR): _____ml/min/1.73 m^2

Most recent evaluation Date: YYYY-MM-DD

Creatinine clearance: _____ml/min **or**

Estimated glomerular filtration rate (eGFR): _____ml/min/1.73 m^2

❒ Benefits in terms of renal pain

Specify: _____

❒ Other, specify: _____

Section 8 : Additional information