



PRIOR AUTHORIZATION REQUEST FORM
Aflibercept (Eylea®) / Macular oedema secondary
to retinal vein occlusion (RVO)

DECLARATION OF THE INSURED PERSON

Section 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 (YYYY/MM/DD)	Telephone	
Address (house number and street name)	City/Town	Province	Postal code

Section 2 : Other prescription drug insurance policies

Do you have other prescription drug insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, please answer the following:			
What type of plan is it?	<input type="checkbox"/> Private	<input type="checkbox"/> Public	
Have you ever submitted a claim for this drug to the other insurer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What is the status of the claim?	<input type="checkbox"/> Accepted	<input type="checkbox"/> Refused	<input type="checkbox"/> Under review
Did this insurer ask you to complete a prior authorization request?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, what is the status of the prior authorization request?	<input type="checkbox"/> Accepted	<input type="checkbox"/> Refused	<input type="checkbox"/> 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.

_____ Signature of patient (parent/legal guardian)	<u>YYYY-MM-DD</u> Date
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IMPORTANT :

All correspondence concerning this form will be sent to the address indicated in the plan member'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
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.		
_____ Signature of prescriber		<u>YYYY-MM-DD</u> Date

Section 5 : Drug covered by the authorization			
Drug name	Pharmaceutical form	Strength	Dosage: Dose: _____ Frequency: _____
Type of request	<input type="checkbox"/> Demande initiale Complete section 6		
	<input type="checkbox"/> Continuation of treatment Complete section 7 Also complete section 6 if this is the first authorization requested from SSQ		

IMPORTANT:

To ensure sound management of its group insurance plans, SSQ gives preference to the use of biosimilar drugs. Eligibility for reference biologic products is subject to certain conditions.



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IMPORTANT:

Please do not provide any genetic test results

Section 6 : Clinical information (First request)

Therapeutic indication

- ☐ Macular oedema secondary to retinal vein occlusion (RVO)
☐ Other. Specify: _____

Left eye

Right eye

Administration of the drug covered by the authorization

- | | |
|--|--|
| <input type="checkbox"/> Monotherapy
<input type="checkbox"/> In conjunction:
Specify agent: _____ | <input type="checkbox"/> Monotherapy
<input type="checkbox"/> In conjunction:
Specify agent: _____ |
|--|--|

Optimum visual acuity after correction

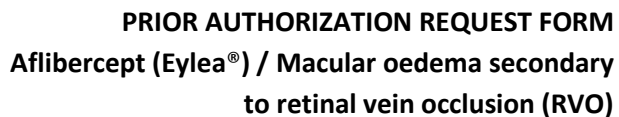
- | | |
|---|---|
| <input type="checkbox"/> Between 6/12 and 6/120
<input type="checkbox"/> Other. Specify: _____ | <input type="checkbox"/> Between 6/12 and 6/120
<input type="checkbox"/> Other. Specify: _____ |
|---|---|

Thickness of the central retina

- | | |
|--|--|
| <input type="checkbox"/> $\geq 250\mu\text{m}$
<input type="checkbox"/> Other. Specify: _____ | <input type="checkbox"/> $\geq 250\mu\text{m}$
<input type="checkbox"/> Other. Specify: _____ |
|--|--|

Afferent pupillary defect

- | | |
|---|---|
| <input type="checkbox"/> Absence
<input type="checkbox"/> Presence | <input type="checkbox"/> Absence
<input type="checkbox"/> Presence |
|---|---|



Information necessary to evaluate the response to treatment

Left eye	Right eye
Visual acuity measured by Snellen test	
Date : <u>YYYY-MM-DD</u> <input type="checkbox"/> Stabilization <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration	Date : <u>YYYY-MM-DD</u> <input type="checkbox"/> Stabilization <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration
Macular oedema evaluated by optical coherence tomography	
Date : <u>YYYY-MM-DD</u> <input type="checkbox"/> Stabilization <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration	Date : <u>YYYY-MM-DD</u> <input type="checkbox"/> Stabilization <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration

Section 8 : Additional information

[illegible]