PRIOR AUTHORIZATION REQUEST FORM
Omalizumab (Xolair®)/Allergic asthma

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 (number and street name)	City/Town	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

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. _____ YYYY-MM-DD Signature of **prescriber** Date		

Section 5 : Drug covered by the authorization			
Drug name **Omalizumab (Xolair®)**	Pharmaceutical form Powder for subcutaneous injection	Strength 150 mg/vial	Dosage Dose: _____ mg 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:
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.

IMPORTANT:
Please do not provide any genetic test results

Section 6 : Clinical information (First request)

Diagnosis

❒ Severe asthma

❒ Other, specify: _____

Please provide the following

Patient's weight: _____ kg IgE level (before treatment): _____ UI/ml

Number of exacerbations requiring use of **systemic** corticosteroids, an emergency room visit or hospitalization in the last year ***or*** an increased dose of systemic corticosteroid used in maintenance treatment _____

Section 6 :Clinical information (First request cont'd)		
Summary of previous trials or contraindications		
Drug or other medical treatment	**Reason for discontinuation**	**Duration of treatment**
Inhaled corticosteroids (ICS) Name:_____ Dose:_____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Long acting β-agonist (LABA) Name:_____ Dose:_____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Leukotriene receptor antagonist (LTRA) Name:_____ Dose:_____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Systemic corticosteroid Name:_____ Dose:_____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Long acting antimuscarinic Name:_____ Dose:_____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Theophylline Name:_____ Dose:_____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Other Name:_____ Dose:_____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD

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

Please indicate the results of one of the following questionnaires

- ❒ *Asthma Control Questionnaire* (ACQ): _____ Date: YYYY-MM-DD
- ❒ *Asthma Control Test* (ACT): _____ Date: YYYY-MM-DD
- ❒ *St. George's Respiratory Questionnaire* (SGRQ): _____ Date: YYYY-MM-DD
- ❒ *Asthma Quality of Life Questionnaire* (AQLQ): _____ Date: YYYY-MM-DD

Other information

Was the inhalation technique verified?	❒ Yes	❒ No
Was the adherence to pharmacological treatment verified?	❒ Yes	❒ No
Was the skin test or in vitro reactivity test for aperiodic pneumoallergen positive?	❒ Yes	❒ No
Were strategies to reduce exposure to pneumoallergens implemented?	❒ Yes	❒ No
Was oral corticosteroid taken on an ongoing basis for at least 3 months?	❒ 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

Information required to assess the response to treatment with respect to the first evaluation

	Evaluation before the treatment began	**Last evaluation**
Asthma Control Questionnaire (ACQ)	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____
Asthma Control Test (ACT)	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____
St. George's Respiratory Questionnaire (SGRQ)	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____
Asthma Quality of Life Questionnaire (AQLQ)	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____

Number of exacerbations requiring use of systemic corticosteroids or an increase in dose if used in maintenance treatment

In the year **before treatment began** Number: _____

In the **last** year Number: _____

Oral corticosteroid taken on an **ongoing** basis BEFORE the introduction of Xolair®:

❒ Yes ❒ No

Specify the corticosteroid used: _____

Dose before the introduction of Xolair®: _____mg/day

Current dose: _____mg/day

Other positive effects observed since the introduction of Xolair®

Section 8 : Additional information