PRIOR AUTHORIZATION REQUEST FORM

DECLARATION OF THE INSURED PERSON

Section 1: Information about the participant and the patient

Name of participant	Police / certificat	Name of employer	
Name of patient	Date de naissance (AAAA/MM/JJ)	Telephone	
Address (house number and street name)	Ville	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.

Signature of **patient** (parent/legal guardian) _____ Date YYYY-MM-DD

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

PRIOR AUTHORIZATION REQUEST FORM

DECLARATION OF THE PRESCRIBER

Section 4: Information about the prescriber		
Name of prescriber	Specialty	Licence No.:
Telephone	Fax	
I hereby certify that the information in this request is complete, true and accurate: Signature of **prescriber** _____ Date YYYY-MM-DD		

Section 5: Drug covered by the authorization			
Drug name	Phramaceutical 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 your first authorization request from SSQ
Injection – where the drug is administered: ❒ Home ❒ Outpatient ❒ CHSLD ❒ Doctor's office ❒ While hospitalized ❒ Other Please specify_____ Exact name and address:			

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 Specify:_____ Date the symptoms began: YYYY-MM-DD

Section 6: Clinical information (First request) (suite)

Lab test results that are relevant to this request **BEFORE** the start of requested treatment (e.g., Hb, LDL-Chol, etc.)

Type of test	Result	Date
		YYYY-MM-DD
		YYYY-MM-DD
		YYYY-MM-DD

Results using recognized scales/standards for assessing the severity of the condition **BEFORE** the start of requested treatment (e.g.: DLQI, HAQ, ECOG, etc.)

Scale/Standard	Result	Date
		YYYY-MM-DD
		YYYY-MM-DD
		YYYY-MM-DD

Results of clinical examinations relative to this request **BEFORE** the start of requested treatment (e.g.: imaging, investigative report, etc.)

Examination	Result	Date
		YYYY-MM-DD
		YYYY-MM-DD
		YYYY-MM-DD

Summary of previous trials or contraindications

Drug or other medical treatment	**Reason for stopping**	**Duration of treatment**
Name: ________________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: ___________________	fromYYYY-MM-DD to YYYY-MM-DD
Name: ________________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: ___________________________________	fromYYYY-MM-DD to YYYY-MM-DD
Name: ________________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: ___________________________________	fromYYYY-MM-DD to YYYY-MM-DD
Name: ________________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: ___________________________________	fromYYYY-MM-DD to YYYY-MM-DD
Name: ________________ Dosage: ____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: ___________________________________	fromYYYY-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

Diagnosis
Specify: _____

Comparison of lab test results relevant to the present authorization request **BEFORE** and **AFTER** the start of the requested treatment (e.g.: Hb, LDL-Chol, etc.)

Type of test	Initial evaluation	Most recent subsequent evaluation
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD

Section 7: Clinical information (Continuation of treatment) (cont'd)

Comparison of results using recognized scales/standards for assessing the severity of the condition **BEFORE** and **AFTER** the start of requested treatment (e.g.: DLQI, HAQ, ECOG, etc.)

Scale/Standard	Initial evaluation	Most recent subsequent evaluation
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD
	Result: _____ Date: YYYY/MM/DD	Result: _____ Date: YYYY/MM/DD

Results of recent clinical examinations relevant to the evaluation of the response to treatment requested (e.g.: imaging)

Clinical examination	Result	Date
		YYYY/MM/DD
		YYYY/MM/DD

Other beneficial effects observed since the start of treatment:

Section 8: Additional information