PRIOR AUTHORIZATION REQUEST FORM

Ruxolitinib (Jakavi®) / Polycythemia vera

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?		❒ 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 _____

IMPORTANT :

All correspondence concerning this form will be sent to the address indicated in the participant'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

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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 _____		

Section 5 : Drug covered by the authorization			
Name of drug Ruxolitinib	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 ❒ Polycythemia vera ❒ Other. Specify: _____
Complete the following information Current value of the ECOG's performance status ❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4

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

Summary of the previous trial with hydroxyurea

Period:

From _____ to _____

Dose:

❒ At least 2 g per day.

❒ At maximum efficacy dosage that doesn't lead to grade 3 or higher hematological, skin or digestive toxicity.

❒ Other. Specify: _____

❒ Resistance to hydroxyurea observed by:

- ❒ The use of more than one phlebotomy over a period of 3 months to maintain the packed cell volume (hematocrit) at 45%
- ❒ A white blood cell (leucocyte) count over 10 x 10^9/L and a platelet count over 400 x 10^9/L.
- ❒ A persistence of symptoms linked to an enlarged spleen.

❒ Other. Specify: _____

Section 7 : Clinical information (continuation of treatment)

Information necessary to evaluate the response to treatment

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

Current value of the ECOG's performance status

❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4

Clinical benefits observed (**first renewal**)

❒ Reduced use of phlebotomy to maintain the packed cell volume (hematocrit) at 45%

❒ Improved thrombocytosis and leucocytosis

❒ Improved symptoms linked to an enlarged spleen

❒ Other. Specify: _____

Beneficial clinical effect observed (**subsequent renewals)**

❒ Maintenance of clinical benefits on:

- ❒ The frequency of using phlebotomy
- ❒ The platelets and white blood cell count
- ❒ Symptoms linked to an enlarged spleen
- ❒ Other. Specify: _____

❒ Other. Specify: _____

Section 8 : Additional information