PRIOR AUTHORIZATION REQUEST FORM

Sofosbuvir/velpatasvir/voxilaprevir (Vosevi®) / Chronic hepatitis C

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

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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	Pharmaceutical form	Strength	**Dosage** Dose: _____ Frequency of administration: _____

IMPORTANT:

Please do not provide any genetic test results

Section 6 : Clinical information

Diagnosis

❒ Chronic Hepatitis C in compliance with Health Canada indication

For informational purposes only:

VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) is indicated for the treatment of chronic hepatitis C virus (HCV) infection in adult patients, without cirrhosis or with compensated cirrhosis, who have:

- genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor.
- genotype 1, 2, 3, or 4 infection and have been previously treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.

❒ Other. Specify: _____

Administration of Vosevi®

❒ Monotherapy

❒ Other. Specify: _____

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

Presence of decompensated cirrhosis

❒ Yes ❒ No

Summary of previous trials or contraindications

TREATMENT FOR HCV	Duration of treatment
❒ Was never treated for HCV	
❒ Unsuccessful HCV treatment ❒ Daclatasvir ❒ Elbasvir ❒ Ledipasvir ❒ Ombitasvir ❒ Pibrentasvir ❒ Velpatasvir ❒ Other: _____ ❒ Unsuccessful Sofosbuvir-based treatment, without NS5A inhibitor ❒ Other. Specify: _____	From _____ To _____

Section 7 : Additional information