**PRIOR AUTHORIZATION REQUEST FORM**

**Ocrelizumab (Ocrevus®) / Relapsing-Remitting Multiple Sclerosis (RRMS)**

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**
**Ocrelizumab (Ocrevus®) / Relapsing-Remitting Multiple Sclerosis (RRMS)**

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:<br><br>Signature of **prescriber** _____ Date _____ | | |

| Section 5: Drug covered by the authorization | | | |
|---|---|---|---|
| Name of drug | Pharmaceutical form | Strength | **Dosage**<br>Dose: _____<br>Frequency of administration:<br>_____ |
| Type of request | ❒ First request<br>Complete section 6 | | ❒ Continuation of treatment<br>Complete section 7<br>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**<br>❒ Relapsing-Remitting Multiple Sclerosis (RRMS)<br>❒ Other. Specify : _____ | | |
| **Administration**<br>❒ Monotherapy<br>❒ Other. Specify : _____ | | |
| **Progress of the disease** | | |
| | **Result** | **Evaluation date** (YYYY-MM-DD) |
| EDSS **before** the start of treatment with Ocrevus | _____ | _____ |
| At least one relapse in the last year:<br>❒ No<br>❒ Yes. Date (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): _____

**Progress of the disease**

| | **Result** | **Evaluation date** (YYYY-MM-DD) |
|---|---|---|
| EDSS **before** the start of treatment with Ocrevus | _____ | _____ |
| Current EDSS | _____ | _____ |

Beneficial effect defined by the absence of deterioration

❒ No

❒ Yes. Specify: _____

## Section 8: Additional information