**PRIOR AUTHORIZATION REQUEST FORM**
**Golimumab (Simponi®) / Non-Radiological Axial Spondyloarthritis**

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**
**Golimumab (Simponi®) / Non-Radiological Axial Spondyloarthritis**

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 | | | |
|---|---|---|---|
| Simponi | Pharmaceutical form | Strength | **Dosage**<br>Dose: _____<br>Frequency of administration:<br>_____ |
| Type of request | ❒ First request | | ❒ Continuation of treatment |

**IMPORTANT:**

**Please do not provide any genetic test results**

| Section 6: Clinical information – First request |
|---|
| **Diagnosis**<br>❒ Non-Radiological Axial Spondylarthritis<br>❒ Other. Specify: _____ |
| **Evaluation before the start of treatment with the requested prescription drug**<br>Evaluation date:_____<br>Symptoms onset date: _____<br>BASDAI (scale of 0 to 10):_____<br>BASFI (scale of 0 to 10):_____<br><br>Presence of objective signs of inflammation:<br>□ Elevated levels of C-reactive protein<br>Result: _____ Date: _____<br>and/or<br>□ Signs visible on MRI<br>Exam date: _____ |

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

**Summary of previous tests or contraindications**

| NSAID | Reason for stopping | | | Duration of treatment |
|---|---|---|---|---|
| **Name: _____**<br>Dosage: _____ | ❒ Ineffective | ❒Intolerance | ❒Contraindication | From_____<br>to _____ |
| | ❒ Other<br>Specify: _____ | | | |
| **Name: _____**<br>Dosage: _____ | ❒ Ineffective | ❒Intolerance | ❒Contraindication | From_____<br>to _____ |
| | ❒ Other<br>Specify: _____ | | | |
| **Name: _____**<br>Dosage: _____ | ❒ Ineffective | ❒Intolerance | ❒Contraindication | From_____<br>to _____ |
| | ❒ Other<br>Specify: _____ | | | |
| **No NSAID** | ❒ Contraindication<br>❒ Other<br>Specify: _____ | | | |
| | ❒ Other<br>Specify: _____ | | | |

## Section 7: Clinical information (Continuation of treatment)

Information required to evaluate the response to treatment

The prescription drug that is the subject of this request began on: _____

| Information on the evaluation | First evaluation | Subsequent evaluation |
|---|---|---|
| Date | YYYY-MM-DD | YYYY-MM-DD |
| BASDAI (0 to 10) | | |
| BADSFI (0 to 10) | | |
| Return to work | N/A | ❒ Yes<br>❒No<br>❒ N/A |

| Section 8: Complementary information |
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