**PRIOR AUTHORIZATION REQUEST FORM**
**Obeticholic acid (Ocaliva®) / Primary biliary cholangitis**

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**
**Obeticholic acid (Ocaliva®) / Primary biliary cholangitis**

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<br><br>Obeticholic acid | Pharmaceutical form | Strength | **Dosage**<br>Dose: _____<br>Frequency of administration:<br>_____ |
| Expected duration of treatment: From _____ to ❒ indeterminate or _____ | | | |
| If the patient is hospitalized, indicate the expected date of discharge: _____ | | | |
| 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 |

**PRIOR AUTHORIZATION REQUEST FORM**
**Obeticholic acid (Ocaliva®) / Primary biliary cholangitis**

**IMPORTANT:**

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

## Section 6 : Clinical information (first request)

**Diagnosis**

❒ Primary biliary cholangitis

❒ Other. Specify: _____

**Administration of obeticholic acid**

❒ With ursodiol

❒ In monotherapy

❒ Other. Specify: _____

| | | |
|---|---|---|
| **Trial Summary**<br><br>**Ursodiol** | ❒ Unsatisfactory response<br>❒ Intolerance<br>❒ Other<br>Specify: _____<br>_____ | From<br>_____<br><br>To<br>_____ |

**Lab test results BEFORE start of treatment with obeticholic acid**

❒ Alkaline phosphatase (ALP) level of at least 1.67 times the upper limit of normal

ALP: _____ U/L

❒ Total bilirubin level exceeds the upper limit of normal, but is less than 2 times the limit amount

Total bilirubin: _____ µmol/l

| Section 7 : Clinical information (continuation of treatment) | | |
|---|---|---|
| **Information necessary to evaluate the response to treatment** | | |
| **Information regarding evaluation** | **Initial evaluation** | **Most recent subsequent evaluation** |
| **Report date** | _____ | _____ |
| **Alkaline phosphatase (ALP) level**<br><br>**Total bilirubin level** | ALP: _____ U/L<br><br>Total bilirubin: _____µmol/l | ALP: _____ U/L<br><br>Total bilirubin: _____µmol/l |

| Section 8 : Additional information |
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