PRIOR AUTHORIZATION REQUEST FORM

Abatacept (Orencia®), adalimumab (Abrilada®, Amgevita®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Simlandi®, Yuflima®), etanercept (Brenzys®, Enbrel®, Erelzi®), infliximab (Remicade®)/ Juvenile idiopathic arthritis of polyarticular or systemic form

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			
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
What is the status of the prior authorization?	❒ 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 the 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 the completed form by email or by fax at: 1-855-453-3942.

Telephone: 418-651-2588/1-800-380-2588 – Fax: 1-855-453-3942

Addresse: 2525 Laurier Blvd, P.O. Box 10500, Quebec City QC G1V 4H6

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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 accurate. _____ _____ Signature of **prescriber** Date		

Section 5: Drug covered by the authorization			
Name of Drug	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
For Injection – Location where the drug is to be administered: ❒ Home ❒ Outpatient ❒ CHSLD ❒ Doctor's office ❒ Patient is hospitalized ❒ Other. Specify_____ Exact name and address:			

IMPORTANT:
To ensure sound management of its group insurance plan, SSQ gives preference to the use of biosimilar drugs. The eligibility of claims for brand-name drugs is subject to certain conditions.

IMPORTANT:

Please do not provide genetic test results

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Section 6: Clinical Information (first request)

Evaluation immediately before the start of treatment with the requested drug

Date: _____

Number of joints with active synovitis: _____

Provide at least one of the following

Value of the C-reactive protein _____mg/l

Value of the sedimentation rate _____mm/h

Summary of trials with methotrexate

Methotrexate

Dosage: _____ ❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other from_____

Specify: _____ to_____

_____

Section 7: Clinical Information (continuation of treatment)

Information necessary to evaluate, <u>after five months or more,</u> the response to treatment based on the points evaluated initially

Information related to the evaluation	First evaluation Date:	Most recent evaluation Date:
Number of joints with active synovitis: _____		
Number of joints affected by limitation of movement: _____		
Value of the C-reactive protein	mg/l	mg/l
Value of sedimentation rate	mm/h	mm/h
Score on the pediatric health questionnaire (CHAQ) or a return to school		
Overall evaluation of the physician, the individual or the parent (visual analogue scale)		

Section 8: Additional information