

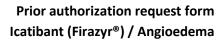
DECLARATION OF THE INSURED PERSON

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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		_					
Do you have other prescription drug insura	ance?	☐ Yes	□ No				
If so, please answer the following: What type of plan is it?		☐ Private	☐ Public				
Have you ever submitted a claim for this d	☐ Yes	☐ No					
What is the status of the claim?	☐ Accepted		☐ Under review				
Did this insurer ask you to complete a prio		☐ Yes	☐ No				
If so, what is the status of the prior au		☐ Under review					
Please enclose acceptance or refus	•	a B Keruseu	D onder review				
Trease enclose deceptance of reju.	загаоситентя, у аррисаыс						
Section 3: Authorization to disclose	e personal information						
I certify that the information in this pr		e, accurate and t	rue.				
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 I '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)							
Signature of patient (parent/legal)	guarulari)	Dat	.c				
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							



DECLARATION OF THE PRESCRIBER

Section 4: Information about the prescriber						
Name of 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 _				D	Pate	
Section 5 : Drug covered	by the authorization					
Name of drug Icatibant	Pharmaceutical form	Strer	ngth	Dosage Dose: Frequency o	f administration:	
IMPORTANT: Please do not provide any genetic test results						
Section 6 : Clinical information Therapeutic indication For treatment of acute attacks of angioedema in compliance with Health Canada Indication.						
For informational purposes	_	соп	ipiiariee wi	tii ricaitii ca	nada malcation.	
FIRAZYR (icatibant acetate) is indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults, adolescents and children aged 2 years and older with C1-esterase inhibitor deficiency.						
☐ Other. Specify :						
Results of the laboratory analysis						
C1 antigenic inhi	bitor : 🗖 Low 🗖	Norma	al 🗖 High			
	ibitor : 🗆 Low 🗆	Norma		•		
Number of attack						
☐ At least one medically confirmed acute attack of angioedema						
☐ Other. Specify :						





Section 7 : Additional information		