



PRIOR AUTHORIZATION REQUEST FORM
Ibrutinib (Imbruvica®) / Mantle-cell lymphoma

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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, please answer the following: | | |
| What type of plan is it? | <input type="checkbox"/> Private | <input type="checkbox"/> Public |
| Have you ever submitted a claim for this drug to the other insurer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| What is the status of the claim? | <input type="checkbox"/> Accepted | <input type="checkbox"/> Refused |
| | | <input type="checkbox"/> Under review |
| Did this insurer ask you to complete a prior authorization request? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, what is the status of the prior authorization request? | <input type="checkbox"/> Accepted | <input type="checkbox"/> Refused |
| | | <input type="checkbox"/> 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

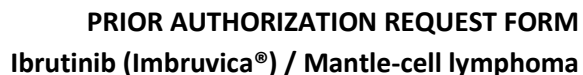
DECLARATION OF THE PRESCRIBER

| 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: | | |
| Signature of prescriber _____ | | Date _____ |

| Section 5 : Drug covered by the authorization | | | |
|---|--|----------|--|
| Name of drug | Pharmaceutical form | Strength | Dosage Dose: _____ Frequency of administration: _____ |
| Imbruvica | Capsule | 140 mg | |
| Type of request | <input type="checkbox"/> First request Complete section 6 <input type="checkbox"/> Continuation of treatment Complete section 7 Also complete section 6 if this is the first authorization requested from SSQ | | |

| |
|--|
| <p>IMPORTANT:</p> <p>Please do not provide any genetic test results</p> |
|--|

| Section 6 : Clinical information (first request) | |
|---|--|
| Diagnosis <input type="checkbox"/> Recurrent or refractory mantle-cell lymphoma <input type="checkbox"/> Other. Specify : _____ | |
| Imbruvica administration <input type="checkbox"/> As monotherapy <input type="checkbox"/> Other. Specify : _____ | |
| Performance status ACTUAL value ECOG <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | |



Summary of previous treatments or contraindications

Section 7 : Clinical information (continuation of treatment)

Treatment was started on (YYYY-MM-DD): _____

- Section 8 : Additional information

[illegible]