PRIOR AUTHORIZATION REQUEST FORM

OnabotulinumtoxinA (Botox®) / Severe axillary hyperhidrosis in adults

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
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 at: 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

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DECLARATION OF THE PRESCRIBER

Section 4: Information about the prescriber		
Name of Prescriber	Speciality	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 OnabotulinumtoxinA	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:

Please do not provide any genetic test results

Section 6: Clinical information (first request)

Diagnosis

❒ Severe axillary hyperhidrosis in adults

❒ Other. Specify: ____

Section 6: Clinical information (first request) (cont'd)		
Information on the severity of hyperhidrosis ❒ **Significant** functional and psychosocial **impairment** Describe the impairment observed: ______ ❒ **No significant impairment** (or mild to moderate) functional and psychosocial impairment		
Summary of past trials with an aluminum chloride preparation		
Aluminum chloride Strength of the preparation tried: ______%	❒ Not effective ❒ Intolerance ❒ Contraindication ❒ Other. Specify: ______	From: ______ To: ______

Section 7: Clinical information (continuation of treatment)
Required information to document the evidence of a therapeutic benefit **Reduced sweating** ❒ Yes. Describe the beneficial effects observed: ______ ❒ No. Expected benefits with continued treatment: ______ **Improvement** of **functional AND psychosocial** impairment ❒ Yes. Describe the beneficial effects observed: ______ ❒ No. Expected benefits with continued treatment: ______

Section 8: Additional information