PRIOR AUTHORIZATION REQUEST FORM
Burosumab (Crysvita®) / Hypophosphatemia

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
Burosumab (Crysvita®) / Hypophosphatemia

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 Burosumab (Crysvita)	Pharmaceutical form	Strength	**Dosage** Dose: _____ Frequency of administration: _____ Weight: _____
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
Injection – administered at: ❒ Home ❒ Outpatient clinic ❒ CHSLD ❒ Doctor's office ❒ Hospital (patient is admitted) ❒ Other Specify_____ Exact location's name and address:			

PRIOR AUTHORIZATION REQUEST FORM
Burosumab (Crysvita®) / Hypophosphatemia

IMPORTANT:

Please do not provide any genetic test results

Section 6: Clinical information (first request)

Diagnosis :

❒ Diagnosis of hypophosphatemia in compliance with Health Canada Indication

For informational purposes only:

CRYSVITA (Burosumab Injection) is indicated for the treatment of X-linked hypophosphataemia (XLH) in adult and pediatric patients 6 months of age and older.

❒ Confirmation method : _____

❒ Other: _____

Does the patient have signs and symptoms of the disease? (Musculoskeletal pain, rickets, fracture, …)?

❒ Yes
Specify :_____
_____
_____

❒ No

Laboratory results

What is the last serum phosphorus level?

Result: _____ Date: _____ Normal value according to age: _____

What is the TmP/GFR of the patient?

Result : _____ Date : _____Normal value : _____

What is the patient's latest glomerular filtration rate (GFR)?

Result: _____ Date: _____

Other

Do you plan to stop oral phosphate and Vitamin D active analogues at least 1 week before starting Crysvita treatment?

❒ Yes

❒ No

Section 6: Clinical information (first request) (cont'd)

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Category Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From _____ To _____
Category Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From _____ To _____

Section 7: Clinical information (continuation of treatment)

Information necessary to evaluate the response to treatment

The drug covered by the present authorization request was first taken on (YYYY-MM-DD): _____

What is the last serum phosphorus level?

Result: _____ Date: _____ Normal value according to age: _____

Has there been improvement in the patient's symptoms?

❒ Yes
Specify :_____
_____
_____
_____

❒ No

Section 8: Additional information