PRIOR AUTHORIZATION REQUEST FORM
Apalutamide (Erleada®) / Prostate cancer

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

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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 complete, true and accurate: Signature of **prescriber** _____ Date _____		

Section 5: Drug covered by the authorization			
Name of drug Erleada	Pharmaceutical form Tablets	Strength 60mg	**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

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IMPORTANT:

Please do not provide any genetic test results

Section 6: Clinical information (first request)

Diagnosis

- ❒ Treatment of **metastatic** castration-sensitive prostate cancer
  - ❒ Metastatic disease documented by at least one lesion present on bone scanning
  - ❒ Under concomitant androgenic deprivations therapy
  - ❒ Other. Specify: _____
- ❒ Treatment of **non-metastatic** castration-resistant prostate cancer.
  - ❒ At high risk (PSA doubling time ≤ 10 months) of developing distant metastases despite androgen deprivation treatment.
  - ❒ Other. Specify: _____
- ❒ Other. Specify: _____

ACTUAL performance status

ECOG ❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4

Summary of previous trials or contraindications

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

Section 7: Clinical information (continuation of treatment)

Information necessary to evaluate the response to treatment

Treatment was first taken on (YYYY-MM-DD): _____

❒ Absence of disease progression

❒ Other. Specify: _____

Section 8: Additional information