PRIOR AUTHORIZATION REQUEST FORM
Elexacaftor/tezacaftor/ivacaftor (Trikafta®)/Cystic fibrosis

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 **Trikafta®** Elexacaftor/tezacaftor/ivacaftor	**Pharmaceutical form**	**Strength**	**Dosage** ❒ Two tablets in the morning and one tablet in the evening ❒ Other, specify: _____
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

IMPORTANT:
Please do not provide any genetic test results

Section 6: Clinical information (First request)
Diagnosis ❒ Cystic fibrosis responding to Health Canada approved treatment Reference: *Health Canada approved Trikafta as a triple-combination therapy for people with cystic fibrosis (CF), ages 6 and up, who have at least one F508del mutation, the gene responsible for producing the CFTR (Cystic Fibrosis Transmembrane Regulator) protein.* ❒ Other. Specify: _____

Please provide the following information

Lung transplant recipient: ❒ Yes ❒ No

Pre-treatment FEV_1: _____% of predicted value Date: YYYY-MM-DD

Number of exacerbations necessitating antibiotic therapy in the last 12 months: _____

Pre-treatment result of the Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score: ____

Body Mass Index (BMI) : _____

OR

BMI-for-age z-score for the paediatric population : _____

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 _____

Information required to assess response to treatment since initiation of treatment

	Assessment before initiation of treatment	**Last assessment**
% Forced Expiratory Volume in 1-second (FEV_1)	Date: YYYY-MM-DD Result: _____%	Date: YYYY-MM-DD Result: _____%
CFQ-R respiratory domain score	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____
Number of exacerbations necessitating antibiotic therapy in the last 12 months		
Body Mass Index (BMI) or BMI-for-age z-score for the paediatric population		

Section 8: Additional information