



PRIOR AUTHORIZATION REQUEST FORM
Enoxaparin (Lovenox®)/Anticoagulant treatment

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 Lovenox	Pharmaceutical form	Strength	Dosage Dose: _____ Frequency of administration: _____
Type of request	<input type="checkbox"/> First request <input type="checkbox"/> Continuation of treatment		

IMPORTANT:

To ensure sound management of its group insurance plans, SSQ gives preference to the use of biosimilar drugs. Eligibility for reference biologic products is subject to certain conditions.

IMPORTANT:

Please do not provide any genetic test results

Section 6 : Clinical information

☐ Ongoing treatment with Lovenox **began on** _____ (dd-mm-yyyy)

Section 7 : Additional information
