Prior authorization request form
Eculizumab (Soliris®), Ravulizumab (Ultomiris®) / Paroxysmal nocturnal hemoglobinuria

DECLARATION OF THE INSURED PERSON

Section 1 : Information about the plan member and the patient			
Name of plan member	Policy Certificate	Name of employer:	
Name of patient	Date of birth (YYYY/MM/DD)	Telephone	
Address (number and street name)	Town/City	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.

_____ YYYY-MM-DD

Signature of **patient** (parent/legal guardian) Date

Send us this duly completed for by mail or by fax

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

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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	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:

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IMPORTANT:

Please do not provide any genetic test results

Section 6 : Clinical information (first request)

Diagnosis or clinical context

❒ Symptomatic paroxysmal nocturnal hemoglobinuria

❒ Other. Specify : _____

Hemolysis corroborated by a high serum concentration of lactate dehydrogenase

❒ Yes

❒ No

Health condition (select the corresponding element (s))

❒ A thromboembolic event treated with an anticoagulant ;

❒ The administration of at least 4 red blood cell transfusions in the last 12 months ;

❒ Anemia defined by a hemoglobin serum concentration measured at least twice, < 100 g/L and accompanied by symptoms of anemia, or ≤ 70 g/L ;

❒ Lung failure defined by the presence of disabling dyspnea, thoracic pain limiting activities of daily living or pulmonary arterial hypertension ;

❒ Kidney failure defined by creatinine clearance ≤ 60 mL/min ;

❒ Muscular spasms causing pain, such that its intensity warrants hospitalization or an analgesic treatment with opioids.

Section 7 : Clinical information (continuation of treatment)

Beneficial clinical effect observed

❒ Decrease in the hemolysis corroborated by a significant reduction in the serum concentration of lactate dehydrogenase compared to the serum concentration before the beginning of the treatment.

❒ Other. Specify : _____

Section 8 : Additional information