PRIOR AUTHORIZATION REQUEST FORM
Benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), reslizumab (Cinqair®) / Eosinophilic asthma

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 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	License no.
Telephone	Fax	

I hereby certify that the information in this request is complete, true and accurate.

_____ YYYY-MM-DD

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

IMPORTANT:
Please do not provide any genetic test results

Section 6 : Clinical information (First request)

Diagnosis

❒ Severe eosinophilic asthma

❒ Severe asthma in a patient requiring **continuous oral corticosteroid therapy for ≥ 3 months**

❒ Other Specify: _____

Please provide the following information:

Blood eosinophil count in the bloodstream:

- Date: _____
- Eosinophils: _____x 10^9/L

Number of exacerbations requiring use of systemic corticosteroids or an increased dose, if used as maintenance therapy: _____

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**
Inhaled corticosteroids (ICS) Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Long acting β-agonist (LABA) Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Leukotriene receptor antagonist (LTRA) Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Systemic corticosteroid Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Long acting antimuscarinic Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Theophylline Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Other Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD

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Section 6 : Clinical information (first request cont'd)	
Please indicate the result of one of the following:	
❒ *Asthma Control Questionnaire* (ACQ): _____	Date: YYYY-MM-DD
❒ *Asthma Control Test* (ACT): _____	Date: YYYY-MM-DD
❒ *St. George's Respiratory Questionnaire* (SGRQ): _____	Date: YYYY-MM-DD
❒ *Asthma Quality of Life Questionnaire* (AQLQ): _____	Date: YYYY-MM-DD

Other Information

The inhalation technique was verified ☐ Yes ☐ No

Adherence to pharmacological treatment was verified ☐ Yes ☐ No

Skin test or *in vitro* reactivity test was positive ☐ Yes ☐ No

If yes, have strategies to reduce exposure to pneumoallergens been implemented? ☐ Yes ☐ No

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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

Benefits associated with this ongoing treatment

- ❒ No exacerbation in the past year OR fewer exacerbations per year compared to the year before treatment began
- ❒ Lower dose of systemic corticosteroid used as maintenance therapy (if applicable)
- ❒ Improved control of asthma as demonstrated by a reduction of ≥ 0.5 points in ACQ-5 score
- ❒ Improved quality of life as demonstrated by a reduction of ≥ 4 points in ACQ-5 score

Please indicate at least one of the following:

	Evaluation before first treatment	**Last evaluation**
Results of the ***Asthma Control Questionnaire*** **(ACQ)**	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____
Results of the ***Asthma Control Test*** **(ACT)**	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____
Results of the ***St George's Respiratory Questionnaire*** **(SGRQ)**	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____
Results of the ***Asthma Quality of Life Questionnaire*** **(AQLQ)**	Date: YYYY-MM-DD Score: _____	Date: YYYY-MM-DD Score: _____

Number of exacerbations requiring the use of **systemic corticosteroids** or an increased dose of a systemic corticosteroid if used as maintenance therapy

In the year prior to the start of treatment Number: _____

In the **past** year Number: _____

Oral corticosteroid used as maintenance therapy: ❒ Yes ❒ No

Specify the corticosteroid used and prescribed dosage: _____

Before treatment:

Drug: _____

Dose: _____mg/day

Currently:

Drug: _____

Dose: _____mg/day

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Section 8 : Additional information