PRIOR AUTHORIZATION REQUEST FORM
Edaravone (Radicava®), sodium phenylbutyrate and ursodoxicoltaurine (Albrioza®) / Amyotrophic lateral sclerosis (ALS)

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	Pharmaceutical form	Strength	**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
Injection – administered at: ❒ Home ❒ Outpatient clinic ❒ CHSLD ❒ Doctor's office ❒ Hospital (patient is admitted) ❒ Other Specify_____ Exact location's name and address:			

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.

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IMPORTANT:

Please do not provide any genetic test results

Section 6: Clinical information (first request)

Please specify the degree of certainty of the diagnosis of ALS according to the revised El Escorial's diagnostic criteria (Airlie House criteria):

- ❒ Definite ALS
- ❒ Probable ALS
- ❒ Probable ALS supported by additional examinations
- ❒ Possible ALS

Symptoms start date: _____ (YYYY-MM-DD)

Respiratory function tests

Date of assessment (YYYY-MM-DD): _____

Forced vital capacity (FVC): _____ % of predicted value

Please provide the results of the ALSFRS-R assessment scale before the start of treatment (copy or complete the form attached to the end of the document)

Date of assessment (YYYY-MM-DD): _____

Does the patient have a tracheostomy?

- ❒ Yes
- ❒ No

Most recent creatinine clearance value: _____

How would you describe patient autonomy? _____

Does the patient require invasive ventilation or permanent non-invasive ventilation?

- ❒ Yes
- ❒ No

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
Category Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From _____ To _____
Category Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From _____ To _____
Category Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From _____ To _____

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): _____

Does the patient have a tracheostomy?

- ❒ Yes
- ❒ No

Is the patient able to move and feed themselves without assistance?

- ❒ Yes
- ❒ No

Section 8: Additional information

- ANNEX 1: ALSFRS-R evaluation scale (If no copy, complete the following form)

1. Speech
   - ❒ Normal (4)
   - ❒ Detectable speech disturbance (3)
   - ❒ Intelligible with repeating (2)
   - ❒ Speech combined with nonvocal communications (1)
   - ❒ Loss of useful speech (0)

2. Salivation
   - ❒ Normal (4)
   - ❒ Slight but definite excess of saliva in mouth may have nighttime drooling (3)
   - ❒ Moderately excessive saliva; may have minimal drooling (2)
   - ❒ Marked excess of saliva with some drooling (1)
   - ❒ Marked drooling; requires constant tissue or handkerchief (0)

3. Swallowing
   - ❒ Normal eating habits (4)
   - ❒ Early eating problems; occasional choking (3)
   - ❒ Dietary consistency changes (2)
   - ❒ Needs supplemental tube feedings (1)
   - ❒ Nothing by mouth; exclusively parenteral or enteral feeding (0)

4. Handwriting
   - ❒ Normal (4)
   - ❒ Slow or sloppy; all words are legible (3)
   - ❒ Not all words are legible (2)
   - ❒ Able to grip pen but unable to write (1)
   - ❒ Unable to grip pen (0)

5. Dressing and hygiene
   - ❒ Normal function (4)
   - ❒ Independent and complete self-care with effort or decreased efficiency (3)
   - ❒ Intermittent assistance or substitute methods (2)
   - ❒ Needs attendant for self-care (1)
   - ❒ Total dependence (0)

6. Cutting food and handling utensils
   a) Patient without gastrostomy
      - ❒ Normal (4)
      - ❒ Somewhat slow and clumsy but no help needed (3)
      - ❒ Can cut most foods although clumsy and slow; some help needed (2)
      - ❒ Food must be cut by someone but can still feed slowly (1)
      - ❒ Need to be fed (0)

   b) Patient with gastrostomy
      - ❒ Normal (4)
      - ❒ Clumsy but able to perform all manipulations independently (3)
      - ❒ Some help needed with closures and fasteners (2)
      - ❒ Provides minimal assistance to caregiver (1)
      - ❒ Unable to perform any aspect of task (0)

7. Turning in bed and adjusting bed clothes
   - ❒ Normal (4)
   - ❒ Somewhat slow and clumsy but no help needed (3)
   - ❒ Can turn alone or adjust sheets but with great difficulty (2)
   - ❒ Can initiate but not turn or adjust sheets (1)
   - ❒ Helpless (0)

8. Walking
   - ❒ Normal (4)
   - ❒ Early ambulation difficulties (3)
   - ❒ Walks with assistance (2)
   - ❒ Nonambulatory functional movement (1)
   - ❒ No purposeful leg movement (0)

9. Climbing stairs
   - ❒ Normal (4)
   - ❒ Slow (3)
   - ❒ Mild unsteadiness or fatigue (2)
   - ❒ Needs assistance (1)
   - ❒ Cannot do (0)

10. Dyspnea
    - ❒ None (4)
    - ❒ Occurs when walking (3)
    - ❒ Occurs with one or more of the following: eating, bathing, dressing (2)
    - ❒ Occurs at rest, difficulty breathing when either sitting or lying (1)
    - ❒ Significant difficulty, considering using mechanical respiratory support (0)

11. Orthopnea
    - ❒ None (4)
    - ❒ Some difficulty sleeping at night due to shortness of breaths; does not routinely use > 2 pillows (3)
    - ❒ Needs extra pillows in order to sleep (>2) (2)
    - ❒ Can only sleep sitting up (1)
    - ❒ Unable to sleep (0)

12. Respiratory insufficiency
    - ❒ None (4)
    - ❒ Intermittent use of BiPAP (3)
    - ❒ Continuous use of BiPAP during the night (2)
    - ❒ Continuous use of BiPAP during the night and day (1)
    - ❒ Invasive mechanical ventilation by intubation or tracheostomy (0)