PRIOR AUTHORIZATION REQUEST FORM

Omalizumab (Xolair®) / Moderate or severe chronic idiopathic urticaria

DECLARATION OF THE INSURED PERSON

Section 1: Information about the participant and the patient			
Name of Participant	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			
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 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 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 at: 1-855-453-3942.

Telephone: 418-651-2588 /1-866-332-2588 – 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 PHYSICIAN

Section 4: Information about the physician		
Name of Physician	Specialty	Licence No.:
Telephone	Fax	
I hereby certify that the information in this request is accurate: Signature of **Physician** _____ Date: _____		

Section 5: Drug covered by the authorization			
Name of Drug Xolair	Pharmaceutical Form	Strength	**Dosage** Dose: _____ Frequency of administration: _____

Type of request

❒ First request
Complete Section 6

❒ Request for continuation of treatment after 24 weeks
Complete Section 7
Also complete Section 6 if this is the first authorization requested from SSQ

❒ Subsequent request following a relapse after stopping treatment
Complete Section 8

For injection – Location where prescription drug is to be administered:

❒ Home ❒ Outpatient ❒ CHSLD

❒ Doctor's office ❒ Hospital ❒ Other. Specify_____

Section 6: Clinical information (first request)

Therapeutic indication

❒ For a person suffering from **moderate or severe chronic idiopathic urticaria (CIU)**

❒ Other. Specify. _____

Urticaria Activity Score 7 (UAS7): _____

Summary of pervious tests

ANTIHISTAMINES	RESULTS	TEST PERIOD (IF APPLICABLE)
Name: _____ Dosage (optimized dose): _____	❒ Poor control ❒ Other Specify: _____	From _____ To _____
Name: _____ Dosage (optimized dose): _____	❒ Poor control ❒ Other Specify: _____	From _____ To _____
Other agent Name: _____ Dosage (optimized dose): _____	❒ Poor control ❒ Other Specify:_____	From _____ To _____
Other agent Name: _____ Dosage (optimized dose): _____	❒ Poor control ❒ Other Specify: _____	From _____ To _____

Section 7: Clinical information (continuation of treatment after 24 weeks)

❒ Full response over a period of less than 12 weeks (UAS7 ≤ 6)
❒ Partial response (drop in UAS7 score of at least 9.5 points since the start and UAS7 > 6)

UAS7 scores over the 24 weeks of treatment

Evaluation date: _____ UAS7 score: _____
Evaluation date: _____ UAS7 score: _____
Evaluation date: _____ UAS7 score: _____
Evaluation date: _____ UAS7 score: _____
Evaluation date: _____ UAS7 score: _____
Evaluation date: _____ UAS7 score: _____

Section 8: Clinical information (request following a relapse after stopping treatment)

Previous treatment

Date of last injection: _____

Response:

❒ Satisfactory

UAS7 score: _____

❒ Other. Specify. _____

Current UAS7 score indicating a relapse: _____

Section 9: Additional information