Prior Authorization Request Form

Erenumab (Aimovig®), OnabotulinumtoxinA, botulinum toxin type A (Botox®) / Migraines

DECLARATION OF THE INSURED PERSON

Section 1: Information about the participant and the patient

Name of participant | Policy | Certificate | Name of employer

Name of patient | Date of birth | 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 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 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 PHYSICIAN

Section 4: Information about the prescribing physician

Name of physician | Specialty | License no.

Telephone | Fax

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

Signature of physician | **Date**

Section 5: Drug covered by the authorization

Drug name	Pharmaceutical form	Strength	Dosage
☐ **Onabotulinumtoxin A, Botulinum toxin type A (Botox[MD])**	**Powder for IM injection**	**50 IU** **100 IU** **200 IU**	Dose: _____ Frequency of administration: _____
☐ **Erenumab (Aimovig®)**	**Subcutaneous solution**	**70 mg**	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

Section 6: Clinical information (first request)

Diagnosis

☐ Episodic migraine
☐ Chronic migraine
☐ Other Specify: _____

Provide the following information

Onset of symptoms date	
Number of days with migraine (per month)	
Duration of the migraines (average)	
Frequency of use of Triptan (number of tablets per month)	
Monthly frequency of use of another drug than Triptan (please specify)	

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Name: ____ Dose: ____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ____	From ____ To ____
Name: ____ Dose: ____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ____	From ____ To ____
Name: ____ Dose: ____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ____	From ____ To ____
Name: ____ Dose: ____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ____	From ____ To ____
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: ____

Information required to assess the response to treatment with respect to the first evaluation

	Initial evaluation	Last evaluation
Date		
Number of days with migraine (per month)		
Duration of the migraines (average)		
Frequency of use of Triptan (number of tablets per month)		
Frequency of use of another drug (not Triptan): (number of tablets per month and therapeutic class)		
MIDAS (Migraine Disability Assessment) score		
Number of days of absence from work, if applicable		

Section 8 : Additional information

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