PRIOR AUTHORIZATION REQUEST FORM

Natalizumab (Tysabri®) / Relapsing-Remitting Multiple Sclerosis

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

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 at: 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

PRIOR AUTHORIZATION REQUEST FORM

Natalizumab (Tysabri®) / Relapsing-Remitting Multiple Sclerosis

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 accurate: Signature of **Prescriber** _____ Date _____		

Section 5: Drug covered by the authorization			
Tysabri	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
For injection – Location where prescription drug is to be administered: ❒ Home ❒ Outpatient ❒ CHSLD ❒ Doctor's office ❒ Hospital ❒ Other. Specify_____ Exact name and address:			

IMPORTANT:
To ensure sound management of its group insurance plan, SSQ gives preference to the use of biosimilar drugs. The eligibility of claims for brand-name drugs is subject to certain restrictions.

PRIOR AUTHORIZATION REQUEST FORM

Natalizumab (Tysabri®) / Relapsing-Remitting Multiple Sclerosis

IMPORTANT:

Please do not provide any genetic test results

Section 6: Clinical information (first request)

❒ Multiple Sclerosis (MS)

- ❒ Relapsing-remitting form
- ❒ Secondary progressive stage
- ❒ First acute clinical attack of demyelination

Other. Specify: _____

EDSS **before** starting treatment with **natalizumab**: _____

Evaluation date: _____

Natalizumab will be administered using monotherapy:

❒ Yes ❒No

Progress of the disease over the last year:

❒ **Two or more disabling relapses** with **partial** recovery

❒ **Two or more disabling relapses** with **full** recovery **AND**

- ❒ At least one gadolinium-enhancing lesion on MRI

OR

- ❒ Significant increase in T2-hyperintense lesion load or more compared to a previous MRI

❒ Other. Specify:

_____

_____

Section 7: Clinical information (Continuation of treatment)

❒ Multiple Sclerosis (MS)

- ❒ Relapsing-remitting form
- ❒ Secondary progressive stage
- ❒ First acute clinical attack of demyelination

Other. Specify: _____

EDSS **before** starting treatment with **natalizumab**: _____
Evaluation date: _____

EDSS **now**: _____
Evaluation date: _____

Reduced annual frequency of disabling relapses* over the last year
❒ Yes ❒ No

**By disabling relapse, we mean a relapse during which a neurological exam confirms the presence of optic neuritis, posterior fossa syndrome (brainstem and cerebellum) or symptoms revealing spinal cord trauma (myelitis).*

Section 8: Additional information