



Prior Authorization Request Form

Alirocumab (Praluent®), Evolocumab (Repatha®) / Hypercholesterolemia and clinically manifest atherosclerotic cardiovascular disease

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, please answer the following:			
What type of plan is it?	<input type="checkbox"/> Private	<input type="checkbox"/> Public	
Have you ever submitted a claim FOR THIS DRUG to the other insurer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What is the status of the claim?	<input type="checkbox"/> Accepted	<input type="checkbox"/> Refused	<input type="checkbox"/> Under review
Did this insurer ask you to complete a prior authorization request?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, what is the status of the prior authorization request?	<input type="checkbox"/> Accepted	<input type="checkbox"/> Refused	<input type="checkbox"/> 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
			Dose: _____ Frequency of administration: _____

Type of request First request Continuation of treatment
Complete section 6 Complete section 7
Also complete section 6 if this is the first authorization requested from SSQ

Section 6: Clinical information (first request)

Diagnosis

- Clinically manifest Atherosclerotic cardiovascular disease (Select all of the following that apply):
 - Stable/unstable angina
 - Myocardial infarction
 - Stroke
 - Other, specify: _____
- Other, specify diagnosis: _____

Specify the following information:

Framingham score: _____

Or

Cardiovascular risk level:

- Low
- Moderate
- High

Administration of the prescription drug covered by the authorization

- Monotherapy
- In conjunction with other treatment

Please specify: _____

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
Statin⁽¹⁾ Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Statin⁽²⁾ Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Statin⁽³⁾ Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Fibrates Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Bile-acid sequestrants Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Ezetimibe Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Other agent Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____

Detailed description of intolerances, if any, and CK values, if available

Patient's state of health

Lipid profile	Last result
	Date: _____
	Under which lipid-lowering treatment:
	Name ⁽¹⁾ : _____ Dosage ⁽¹⁾ : _____ Name ⁽²⁾ : _____ Dosage ⁽²⁾ : _____ Name ⁽³⁾ : _____ Dosage ⁽³⁾ : _____
Total Cholesterol	Value: _____ mmol/L
LDL-C	Value: _____ mmol/L
HDL-C	Value: _____ mmol/L
Apo-B	Value: _____ mg/L

