Prior authorization request form

Benralizumab (Fasenra®), mepolizumab (Nucala®), reslizumab (Cinqair™) / Eosinophilic asthma

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

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

Section 6: Clinical information (First request)

Diagnosis

☐ Severe eosinophilic asthma

☐ Severe asthma in a patient requiring **continuous oral corticosteroid therapy for ≥ 3 months**

☐ Other Specify: ____________

Please provide the following information:

Blood eosinophil count in the bloodstream:

Date: ____________ Eosinophils: ____________ x 10^9/L

Number of exacerbations requiring use of systemic corticosteroids or an increased dose, if used as maintenance therapy: ____________

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Inhaled corticosteroids (ICS) Name: ____________ Dose: ____________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: ____________	From ____________ To ____________
Long acting ß-agonist (LABA) Name: ____________ Dose: ____________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: ____________	From ____________ To ____________
Leukotriene receptor antagonist (LTRA) Name: ____________ Dose: ____________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: ____________	From ____________ To ____________
Systemic corticosteroid Name: ____________ Dose: ____________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: ____________	From ____________ To ____________

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
Long acting antimuscarinic Name: ______ Dose: ______	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: ______	From ______ To ______
Theophylline Name: ______ Dose: ______	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: ______	From ______ To ______
Other Name: ______ Dose: ______	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: ______	From ______ To ______

Please indicate the result of one of the following:

☐ *Asthma Control Questionnaire (ACQ):* ______ Date: ______

☐ *Asthma Control Test (ACT):* ______ Date: ______

☐ *St. George's Respiratory Questionnaire (SGRQ):* ______ Date: ______

☐ *Asthma Quality of Life Questionnaire (AQLQ):* ______ Date: ______

Other Information

The inhalation technique was verified: ☐ Yes ☐ No

Adherence to pharmacological treatment was verified: ☐ Yes ☐ No

Skin test or in vitro reactivity test was positive: ☐ Yes ☐ No

If yes, have strategies to reduce exposure to pneumoallergens been implemented? ☐ Yes ☐ No

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: ______

Benefits associated with treatment with Nucala®

☐ No exacerbation in the past year OR fewer exacerbations per year compared to the year before treatment began

☐ Lower dose of systemic corticosteroid used as maintenance therapy (if applicable)

☐ Improved control of asthma as demonstrated by a reduction of ≥ 0.5 points in ACQ-5 score

☐ Improved quality of life as demonstrated by a reduction of ≥ 4 points in ACQ-5 score

Please indicate at least one of the following:

	Evaluation before first treatment	Last evaluation
Results of the ***Asthma Control Questionnaire*** **(ACQ)**	Date: ______ Score: ______	Date: ______ Score: ______
Results of the ***Asthma Control Test*** **(ACT)**	Date: ______ Score: ______	Date: ______ Score: ______
Results of the ***St George's Respiratory Questionnaire*** **(SGRQ)**	Date: ______ Score: ______	Date: ______ Score: ______
Results of the ***Asthma Quality of Life Questionnaire*** **(AQLQ)**	Date: ______ Score: ______	Date: ______ Score: ______

Section 7: Clinical information (continuation of treatment) (cont'd)

Number of exacerbations requiring the use of systemic corticosteroids or an increased dose of a systemic corticosteroid if used as maintenance therapy

In the year prior to the start of treatment with Nucala® Number: ____________________

In the **past** year Number: ____________________

Oral corticosteroid used as maintenance therapy: ☐ Yes ☐ No

Specify the corticosteroid used and prescribed dosage:

Before Nucala®:

Drug: ____________________

Dose: ____________________ mg/day

Currently:

Drug: ____________________

Dose: ____________________ mg/day

Section 8: Additional information