# Prior Authorization Request Form
## Omalizumab (Xolair®)/Allergic 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 |
|---|---|---|---|
| **Omalizumab (Xolair®)** | Powder for subcutaneous injection | 150 mg/vial | Dose: _____<br>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

### Section 6: Clinical information (First request)

**Diagnosis**

☐ Severe asthma

☐ Other, specify: _____

**Please provide the following**

Patient's weight: _____ kg IgE level (before treatment): _____ UI/ml

Number of exacerbations requiring use of **systemic** corticosteroids, an emergency room visit or hospitalization in the last year **or** an increased dose of systemic corticosteroid used in maintenance treatment: _____

**Summary of previous trials or contraindications**

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

## Section 6: Clinical information (First request) (cont'd)

**Please indicate the results of one of the following questionnaires**

☐ *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**

Was the inhalation technique verified? ☐ Yes ☐ No

Was the adherence to pharmacological treatment verified? ☐ Yes ☐ No

Was the skin test or in vitro reactivity test for aperiodic pneumoallergen positive? ☐ Yes ☐ No

Were strategies to reduce exposure to pneumoallergens implemented? ☐ Yes ☐ No

Was oral corticosteroid taken on an ongoing basis for at least 3 months? ☐ 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: _____

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

| | Evaluation before the treatment began | Last evaluation |
|---|---|---|
| ***Asthma Control Questionnaire*** **(ACQ)** | Date: _____<br>Score: _____ | Date: _____<br>Score: _____ |
| ***Asthma Control Test*** **(ACT)** | Date: _____<br>Score: _____ | Date: _____<br>Score: _____ |
| ***St. George's Respiratory Questionnaire*** **(SGRQ)** | Date: _____<br>Score: _____ | Date: _____<br>Score: _____ |
| ***Asthma Quality of Life Questionnaire*** **(AQLQ)** | Date: _____<br>Score: _____ | Date: _____<br>Score: _____ |

Number of exacerbations requiring use of systemic corticosteroids or an increase in dose if used in maintenance treatment

In the year **before treatment began** Number: _____

In the **last** year Number: _____

**Oral** corticosteroid taken on an **ongoing** basis **BEFORE** the introduction of Xolair®:

☐ Yes ☐ No

Specify the corticosteroid used: _____

Dose before the introduction of Xolair®: _____ mg/day

Current dose: _____ mg/day

**Other positive effects observed since the introduction of Xolair®**

_____

_____

_____

## Section 8: Additional information