



PRIOR AUTHORIZATION REQUEST FORM  
Dupilumab (Dupixent™) / Refractory atopic dermatitis

DECLARATION OF THE INSURED PERSON

Section 1: Information about the participant and the patient			
Name of participant	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 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
<b>Please enclose acceptance or refusal documents, if applicable</b>			

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 <b>patient</b> (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**



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DECLARATION OF THE PHYSICIAN

Section 4: Information about the prescribing physician		
Name of physician	Specialty	Licence No.:
Telephone	Fax	
I hereby certify that the information in this request is complete, true and accurate:		
Signature of <b>physician</b> _____		Date _____

Section 5 : Drug covered by the authorization			
Name of drug	Pharmaceutical form	Strength	<b>Dosage</b> Dose: _____ Frequency of administration: _____
Type of request	<input type="checkbox"/> First request Complete section 6		<input type="checkbox"/> 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)	
<b>Diagnosis</b> <input type="checkbox"/> moderate-to-severe chronic atopic dermatitis <input type="checkbox"/> Other. Specify : _____	
<b>Evaluation BEFORE the start of treatment with the prescription drug</b> Date (YYYY-MM-DD): _____ EASI: _____ <b>AND</b> DLQI: _____ Body surface affected (BSA) : <input type="checkbox"/> ≥ 10 % <input type="checkbox"/> < 10 %	



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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
<b>Corticosteroids topical high power <sup>(1)</sup></b> Name : _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ to _____
<b>Corticosteroids topical high power <sup>(2)</sup></b> Name : _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ to _____
<b>Calcineurin inhibitor</b> <input type="checkbox"/> Pimecrolimus <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Other. Specify : _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ to _____
<b>Phototherapy</b> Number of treatments: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ to _____
Name : _____ Dose : _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ to _____
Name : _____ Dose : _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ to _____
Name : _____ Dose : _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> 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 (YYYY-MM-DD): \_\_\_\_\_

**Please provide the result for the two following evaluations:**

<b>Information related to the evaluation</b>	<b>First evaluation</b>	<b>Follow-up evaluation</b>
Date (YYYY-MM-DD)		
EASI		
DLQI		

**Section 8 : Additional information**
