Prior Authorization Request Form
Evolocumab (Repatha®), alirocumab (Praluent®) / Heterozygous familial hypercholesterolemia (HeFH)

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?		❐ 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

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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 **physician** ________________________________ Date _______________

Section 5 : Drug covered by the authorization			
Name of drug	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

Section 6 : Clinical information (first request)

Diagnosis

❒ Heterozygous familial hypercholesterolemia (HeFH) in adult

- Associated artherosclerosis ❒ Yes ❒ No

❒ Other. Specify: ____

Section 6 : Clinical information (first request) (cont'd)	
Confirmation of HETEROZYGOUS familial hypercholesterolemia	
❒ Genotyping	Results must be provided on demand
❒ Phenotyping	At least one of the following elements:
	❒ Family history of HeFH confirmed by genotyping 1st degree relative
	❒ Presence of mutations in LDLR, ApoB or PCSK9 gene of 1st degree relative
	❒ Presence of xanthomas in patient or 1st or 2nd degree relative ❒ Presence of corneal arcus before age 45 in 1st degree relative ❒ Family history of LDL > 4.9 mmol/L in 1st degree adult relative or ≥ 4 mmol/L in 1st degree relative under age 18 years ❒ Family history of total cholesterol of LDL > 7.5mmol/L in 1st degree or 2nd degree adult relative or ≥ 6.7mmol/L in 1st degree or 2nd degree relative under age 16 years

Result of lipid profile

At time of diagnosis

Evaluation date (YYYY-MM-DD): __________________ C-LDL: ____________________ mmol/l

Before beginning of treatment with Evolocumab / Alirocumab

Evaluation date (YYYY-MM-DD): __________________ C-LDL: ____________________ mmol/l

Summary of previous trials or contraindications

Drug or other medical treatment	**Drug or other medical treatment**	**Drug or other medical treatment**
Statin Name: _____________ Dose: _________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: ______________	From _______________ To ________________
Ezetimibe Name: _____________ Dose: _________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: ______________	From _______________ To ________________
No trial	Specify: ________________________________	

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): ________________

Information needed to evaluate response for treatment

	Result BEFORE beginning of treatment with Evolocumab / Alirocumab	**Last result**
C-LDL	Date: ______________________ Value: __________mmol/L	Date: ______________________ Value: _______________mmol/L

Decrease of at least 40% of C-LDL compared with base values at start of treatment with Evolocumab / Alirocumab:	❒ Yes ❒ No

Section 8 : Additional information