PRIOR AUTHORIZATION REQUEST FORM

Imatinib mesylate (Gleevec®) / Gastrointestinal stromal tumor (GIST)

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

PRIOR AUTHORIZATION REQUEST FORM
Imatinib mesylate (Gleevec®) / Gastrointestinal stromal tumor (GIST)

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 **Imatinib mesylate** **GIST**	Pharmaceutical form	Strength	**Dosage** Dose: _____ Frequency of administration: _____
Type of request	❒ First request Complete section 6		❒ **Continuation of treatment ONLY for inoperable, recurrent or metastatic GIST** Complete section 7 Also complete section 6 if this is the first authorization requested from SSQ

Section 6 : Clinical information (first request)

Diagnosis

Gastrointestinal stromal tumor (GIST)

- ❒ Presence of c-KIT receptor (CD117)
- ❒ Absence of c-KIT receptor (CD117)

Therapeutic indication

❒ **Adjuvant treatment of a GIST,** with c-KIT receptor (CD117), **completely resected**

- ❒ High risk of recurrence
- ❒ Intermediate risk of recurrence. Specify: _____
- ❒ Low risk of recurrence. Specify: _____

❒ Treatment of a GIST, with c-KIT receptor (CD117), **inoperable, recurrent or metastatic**

- ❒ Inoperable
- ❒ Recurrent

  Recurrence appeared during adjuvant treatment with imatinib ❒ Yes ❒ No
- ❒ Metastatic

❒ Other. Specify: _____

Section 7 : Clinical information (continuation of treatment) **inoperable, recurrent or metastatic GIST**

Information necessary to evaluate the response to treatment

The drug covered by the present authorization request was first taken on (YYYY-MM-DD): _____

Response to treatment

❒ **Complete or partial** response

❒ **Stabilization** of the disease

❒ **Progression** of the disease

Section 7 : Clinical information (continuation of treatment) **inoperable, recurrent or metastatic GIST (cont'd)**
Confirmation by imaging ❒ Response to treatment **confirmed** by imaging › Date of last imaging: _____ ❒ Response to treatment **NOT confirmed** by imaging › Date of next imaging: _____ › Reason that prevented imaging: _____

Section 8 : Additional information