



Natalizumab (Tysabri®) / Relapsing-Remitting Multiple Sclerosis

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			
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 at: 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



PRIOR AUTHORIZATION REQUEST FORM

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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 accurate:		
Signature of <b>Physician</b> _____		Date _____

Section 5: Drug covered by the authorization			
Tysabri	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
<b>For injection</b> – Location where prescription drug is to be administered:			
<input type="checkbox"/> Home	<input type="checkbox"/> Outpatient	<input type="checkbox"/> CHSLD	
<input type="checkbox"/> Doctor's office	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other. Specify _____	
Exact name and address:			

**Important:**  
To ensure sound management of its group insurance plan, SSQ gives preference to the use of biosimilar drugs. The eligibility of claims for brand-name drugs is subject to certain restrictions.



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Section 6: Clinical information (first request)

- Multiple Sclerosis (MS)
  - Relapsing-remitting form
  - Secondary progressive stage
  - First acute clinical attack of demyelination

Other. Specify: \_\_\_\_\_

EDSS **before** starting treatment with **natalizumab**: \_\_\_\_\_

Evaluation date: \_\_\_\_\_

Natalizumab will be administered using monotherapy:

- Yes       No

Progress of the disease over the last year:

- Two or more disabling relapses** with **partial** recovery
- Two or more disabling relapses** with **full** recovery **AND**
  - At least one gadolinium-enhancing lesion on MRI
  - OR
  - Significant increase in T2-hyperintense lesion load or more compared to a previous MRI
- Other. Specify:

\_\_\_\_\_  
\_\_\_\_\_



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**Section 7: Clinical information (Continuation of treatment)**

- Multiple Sclerosis (MS)
  - Relapsing-remitting form
  - Secondary progressive stage
  - First acute clinical attack of demyelination

Other. Specify: \_\_\_\_\_

EDSS **before** starting treatment with **natalizumab**: \_\_\_\_\_

Evaluation date: \_\_\_\_\_

EDSS **now**: \_\_\_\_\_

Evaluation date: \_\_\_\_\_

Reduced annual frequency of disabling relapses\* over the last year

- Yes       No

\*By disabling relapse, we mean a relapse during which a neurological exam confirms the presence of optic neuritis, posterior fossa syndrome (brainstem and cerebellum) or symptoms revealing spinal cord trauma (myelitis).

**Section 8: Additional information**
