PRIOR AUTHORIZATION REQUEST FORM

Glecaprevir/Pibrentasvir (Maviret®) / Chronic hepatitis C

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

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SSQ insurance

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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: ______________________

Section 6 : Clinical information

Diagnosis

- ❒ Chronic hepatitis C

  Genotype ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6
- ❒ Other. Specify : ____

Administration of Maviret®

- ❒ In monotherapy
- ❒ Other. Specify : ____

Liver damage phase

- ❒ No cirrhosis
- ❒ Compensated cirrhosis
- ❒ Decompensated cirrhosis

Renal function

- ❒ Normal
- ❒ Light to moderate chronic renal failure
- ❒ Severe to terminal chronic renal failure

Section 6 : Clinical information (cont'd)

Summary of previous trials

Anti-HCV treatment	Results	Treatment period (if applicable)
❒ Have never received an anti-HCV treatment		
Treatment based on pegylated interferon alfa ❒ Have never received this treatment ❒ Treatment received : ____________	❒ Therapeutic failure • With an association of ribavirin ❒ Yes ❒ No ❒ Other : ______________________	from____________ to____________
Treatment based on sofosbuvir ❒ Have never received this treatment ❒ Treatment received : ____________	❒ Therapeutic failure • With an association of ribavirin ❒ Yes ❒ No ❒ Other : ______________________	from____________ to____________
NS3/4A protease inhibitor ❒ Have never received this treatment ❒ Treatment received : ____________	❒ Therapeutic failure ❒ Other : ______________________	from____________ to____________
NS5A protein inhibitor ❒ Have never received this treatment ❒ Treatment received : ____________	❒ Therapeutic failure ❒ Other : ______________________	from____________ to____________
Other : ____________________________	**Specify :** ______________________	from____________ to____________

Section 7 : Additional information