

DECLARATION OF THE INSURED PERSON

Section 1: Information about the participant and the patient

Name of participant	Policy / Certificate	Name of employer	
Name of patient	Date of birth	Telephone	
Address (number and street name)	Town/City	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

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

DECLARATION OF THE PHYSICIAN**Section 4: Information about the prescribing physician**

 Name of physician Specialty License 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

Drug name	Pharmaceutical form	Strength	Dosage
			Dose: _____ Frequency of administration: _____

Type of request First request Continuation of treatment
 Complete section 6 Complete section 7
 Also complete section 6 if this is the first authorization requested from SSQ

Section 6 : Clinical information (first request)**Diagnosis**

Advanced or metastatic breast cancer

Other, specify: _____

Complete the following information

Post-menopausal Pre-menopausal

Hormone-receptor-positive Hormone-receptor-negative HER2+ HER2-

Presence of brain cerebral metastases ? Yes No

Actual value of the ECOG performance status

0 1 2 3 4

Administration of Ibrance®:

Administered as first-line metastatic treatment? Yes No

In conjunction with Letrozole

In conjunction with Fulvestrant

In conjunction with Fulvestrant and an LHRH agonist

Other. Specify: _____

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
Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Name: _____ Dosage: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Name: _____ Dosage: _____	<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: _____

Positive clinical effects observed

Date treatment began: _____

Absence of disease progression

Other, specify: _____

Confirmation by imaging

Response to treatment **confirmed** by imaging. Date : _____

Response to treatment **not confirmed** by imaging

• Date of last imaging : _____

• Reasons for why there was no imaging : _____

Section 8: Additional information
