



PRIOR AUTHORIZATION REQUEST FORM
Regorafenib (Stivarga®), trifluridine/tipiracil (Lonsurf®) /
Metastatic colorectal cancer

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?	<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



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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	<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	

Section 6 : Clinical information (first request)
Diagnosis <input type="checkbox"/> Metastatic colon cancer <input type="checkbox"/> Other. Specify: _____
Start date of symptoms (YYYY-MM-DD): _____
Patient with a wild-type KRAS gene: <input type="checkbox"/> Yes <input type="checkbox"/> No
Current value of ECOG performance status: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4



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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
Chemotherapy based on fluoropyrimidine, oxaliplatin and irinotecan. Specify the protocol(s) received: _____ _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other. Specify: _____ _____	From _____ To _____
Anti-VEGF <input type="checkbox"/> Bevacizumab <input type="checkbox"/> Other. Specify: _____ _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other. Specify: _____ _____	From _____ To _____
Anti-EGFR <input type="checkbox"/> Cetuximab <input type="checkbox"/> Panitumumab <input type="checkbox"/> Other. Specify: _____ _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other. Specify: _____ _____	From _____ To _____
Other(s) Name: _____ _____ Dose: _____ _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other. Specify: _____ _____	From _____ To _____

