



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 |
| <i>Please enclose acceptance or refusal documents, if applicable</i> | | | |

| Section 3: Authorization to disclose personal information | |
|---|------------|
| I certify that the information in this prior authorization request is complete, accurate and true. | |
| <p>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.</p> <p>Photocopies of this document have the same value as the original.</p> | |
| 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 | 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"/> Homozygous familial hypercholesterolemia <input type="checkbox"/> Other. Specify: _____ | | |
| Confirmation of homozygous familial hypercholesterolemia | | |
| <input type="checkbox"/> Genotyping | Results must be provided on demand | |
| <input type="checkbox"/> Phenotyping | - C-LDL > 13 mmol/l before the beginning of treatment for hypercholesterolemia - Presence of xanthomas before age 10 - Presence in both parents of familial hypercholesterolemia confirmed | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |



Section 6 : Clinical information (first request) (cont'd)

Recent result of lipid profile

Evaluation date (YYYY-MM-DD): _____

C-LDL: _____ mmol/l

Summary of previous trials or contraindications

| Drug or other medical treatment | Reason for discontinuation | Duration of treatment |
|---|---|------------------------|
| Statin⁽¹⁾ Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Statin⁽²⁾ Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Statin⁽³⁾ Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Fibrates Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Bile-acid sequestrants Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Ezetimibe Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Other agent Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |

