PRIOR AUTHORIZATION REQUEST FORM
Lenalidomide (Revlimid®) / Anemia caused by a myelodysplastic syndrome (MDS) of low-risk or intermediate-1-risk according to the IPSS

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

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	❒ First request Complete section 6		❒ 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)
Myelodysplastic syndrome (MDS) precisions
❒ MDS accompanied by a deletion 5q cytogenetic abnormality ❒ Of low-risk or intermediate-1-risk according to the IPSS ❒ Other. Specify IPSS value : _____ ❒ Other. Specify : _____

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

Anemia characteristics

- Hemoglobin rate (Hb)
  - ❒ < 90 g/L Hb rate: _____ g/L
  - ❒ ≥ 90 g/L Hb rate: _____ g/L

- Transfusion dependence
  - ❒ Yes History of blood transfusions over the past six months:
    _____
  - ❒ No

Section 7 : Clinical information (continuation of treatment)

Necessary information to evaluate treatment response

BEFORE TREATMENT START	EFFECT OBSERVED FOLLOWING TREATMENT
Transfusion **dependence**	❒ Reduction of at least 50% in blood transfusions ❒ Other. Justify treatment continuation : _____ _____ _____ _____
No blood transfusion during the 6 months preceding the beginning of the treatment	• **Increase in Hb rate** in comparison to the rate observed before the beginning of the treatment ❒ ≥15 g/L ❒ <15 g/L Specify : _____ • **Transfusion independence** ❒ Maintained ❒ No. Specify : _____

Section 8 : Additional information