PRIOR AUTHORIZATION REQUEST FORM

Mepolizumab (Nucala®) / Eosinophilic Granulomatosis with Polyangiitis

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

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 at: 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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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 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 Complete section 6		❒ Continuation of treatment Complete Section 7 Also complete Section 6 if this is the first authorization requested from SSQ
For injection – Location where prescription drug is to be administered: ❒ Home ❒ Outpatient ❒ CHSLD ❒ Doctor's office ❒ Hospital ❒ Other. Specify_____ Exact name and address of the administration site:			

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Section 6: Clinical information (first request)

Diagnosis

- ❒ Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) based on a history or presence of eosinophilic asthma (> $1.0x10^9$/L and/or ≥ 10% leukocytes) and at least two of the following characteristics of EGPA (check all that apply).
  - ❒ Biopsy revealing the presence of eosinophilic vasculitis, eosinophilic perivascular infiltration or eosinophilic-rich granulomatous inflammation
  - ❒ Mono- or polyneuropathy
  - ❒ Unfixed pulmonary infiltrates
  - ❒ Sino-nasal abnormality
  - ❒ Cardiomyopathy (confirmed by cardiac ultrasound or MRI)
  - ❒ Glomerulonephritis (hematuria, proteinuria, red cell casts)
  - ❒ Alveolar hemorrhage (confirmed by bronchoalveolar lavage)
  - ❒ Palpable purpura
  - ❒ Detection of anti-neutrophil cytoplasmic antibodies (ANCAs)
- ❒ Other. Please use the eosinophilic asthma form or the general form.

Please provide the following information

Number of eosinophils in the bloodstream:

Date: _____ Eosinophils: _____ x 10^9/L

Is the patient receiving a stable dose of prednisone (or equivalent) orally, ≥ 7.5mg/day and ≤ 50mg/day?

- ❒ Yes
- ❒ No, please specify:

  _____

  _____

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

Please specify if the patient has a history of relapsed or refractory disease as defined below:

- ❒ **Relapsed disease:** a condition that requires an increased dose of oral prednisone; initiated or increased dose of an immunosuppressant, or hospitalization within the past 2 years and at least 12 weeks ago despite a dose of prednisone of at least 7.5mg per day.
- ❒ **Refractory disease:** absence of remission (BVAS score of 0 and a dose of oral prednisone of ≤ 7.5mg/day (or equivalent) in the last 6 months despite standard treatment administered for at least 3 months, or recurrence of symptoms following a decrease in the daily dose of oral prednisone despite a dose of at least 7.5mg per day (or equivalent).

Section 7: Clinical information (Continuation of treatment)

Information required to assess the response to treatment

The drug covered by this request was started on (YYYY-MM-DD): _____

Benefits associated with treatment with Nucala®:

- ❒ Patient currently in remission.
  - ❒ BVAS score:_____ Date: _____
  - ❒ Current daily dose of prednisone: _____/day
- ❒ ≥ 50% reduction in the average daily dose of prednisone compared to initial dose.
- ❒ No relapse in the past year.
- ❒ Other, please specify:
  _____
  _____

Section 8: Additional information