Prior Authorization Request Form

Erenumab (Aimovig®), Galcanezumab (Emgality®), Fremanezumab (Ajovy®), OnabotulinumtoxinA, botulinum toxin type A (Botox®) / Migraines

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?	☐ 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 ____________ 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
☐ **Onabotulinumtoxin A, Botulinum toxin type A (Botox®)**	**Powder for IM injection**	**50 IU** **100 IU** **200 IU**	Dose: ____________ Frequency of administration: ____________
☐ **Erenumab (Aimovig®)**	**Subcutaneous solution**	**70 mg** **140 mg**	Dose: ____________ Frequency of administration: ____________
☐ **Galcanezumab (Emgaliy®)**	**Subcutaneous solution**	**120 mg/mL**	Dose: ____________ Frequency of administration: ____________
☐ **Fremanezumab (Ajovy®)**	**Subcutaneous solution**	**225 mg**	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

Injection – administered at:

☐ Home ☐ Outpatient clinic ☐ CHSLD
☐ Doctor's office ☐ Hospital (patient is admitted) ☐ Other. Specify: ____________

Exact location's name and address ____________

Section 6: Clinical information (first request)

Diagnosis

☐ Episodic migraine

☐ Chronic migraine

☐ Other Specify: ____________

Onset of symptoms date: ____________

Fill in the necessary information

Result on HIT-6 Migraine scale	
Number of days with migraine (per month)	

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Tricyclic antidepressant: Name: ________ Dose: ________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ________	From ________ To ________
Anticonvulsant: Name: ________ Dose: ________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ________	From ________ To ________
Antinypertensive: Name: ________ Dose: ________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ________	From ________ To ________
Other: Name: ________ Dose: ________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other Specify: ________	From ________ To ________
Other: Name: ________ Dose: ________	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ 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: ____________

Information required to assess the response to treatment with respect to the first evaluation

	Initial evaluation	Last evaluation
Date		
Result on HIT-6 Migraine scale		
Number of days with migraine (per month)		

Section 8 : Additional information