Prior Authorization Request Form

Adalimumab (Amgevita®, Hadlima®, Hulio® Humira®, Hyrimoz®, Idacio®) infliximab (Avsola®, Inflectra®, Remicade®, Renflexis™),ustekinumab (Stelara®), vedolizumab (Entyvio®) / Moderate to severe Crohn's disease

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

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

Exact location's name and address

IMPORTANT:

To ensure sound management of its group insurance plans, SSQ gives preference to the use of biosimilar drugs. Eligibility for reference biologic products is subject to certain conditions.

Section 6: Clinical information (first request)

Diagnosis

☐ Moderate or severe Crohn's disease, currently active

☐ Other, specify: _____

Clinical information

Patient's weight: _____ kg

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Corticosteroids Name: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: _____	From _____ To _____
Azathioprine Dose: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: _____	From _____ To _____
Mercaptopurine Dose: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: _____	From _____ To _____
Methotrexate Dose: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other, specify: _____	From _____ To _____

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Anti-TNF(1) Name: _____ Dose: _____	☐ Absence of clinical benefit despite an induction treatment ☐ Loss of clinical benefit ☐ Intolerance, specify: _____ ☐ Contraindication, specify: _____	From _____ To _____
Anti-TNF(2) Name: _____ Dose: _____	☐ Absence of clinical benefit despite an induction treatment ☐ Loss of clinical benefit ☐ Intolerance, specify: _____ ☐ Contraindication, 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: _____

Patient's weight : _____ kg

Positive effects observed:

Section 8: Additional information