



Prior Authorization Request Form

Abatacept (Orencia®), adalimumab (Amgevita®, Hadlima®, Hulio® Humira®, Hyrimoz®, Idacio®),
apremilast (Otezla®), certrolizumab pegol (Cimzia®), etanercept (Brenzys®, Enbrel®,
Erelzi®), golimumab (Simponi®), guselkumab (Tremfya®),
infliximab (Avsola®, Inflectra®, Remicade®, Renflexis®), ixekizumab (Taltz®), secukinumab (Cosentyx®),
tofacitinib (Xeljanz®) ustekinumab (Stelara®) / Moderate or severe psoriatic arthritis of rheumatoid or non-rheumatoid form

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?	<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

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 Continuation of treatment
 Complete section 6 Complete section 7
 Also complete section 6 if this is the first authorization requested from SSQ

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**

- Rheumatoid Psoriatic Arthritis
 Non-Rheumatoid Psoriatic Arthritis
 Other. Specify _____

First evaluation

Date of evaluation _____

Patient's weight: _____ kg

Number of joints with active synovitis: _____

Drug administration

- Monotherapy
 In conjunction with

Specify the associated treatment: _____

Rheumatoid Psoriatic Arthritis		Non-Rheumatoid Psoriatic Arthritis
Please provide at least one of the following:		Health Assessment Questionnaire (HAQ) score: _____
Erosions are visible on x-rays	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Health Assessment Questionnaire (HAQ) score	_____	
C reactive protein (CRP) value	_____ mg/L	
Sedimentation rate value	_____ mm/hr	

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

Summary of previous trials or contraindications		
Drug or other medical treatment	Reason for discontinuation	
Methotrexate Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Azathioprine Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Hydroxychloroquine Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Leflunomide Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Sulfasalazine Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Anti-TNF Name: _____ Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Other biological agent Name: _____ Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Other Name: _____ Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> 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: _____

Evaluation information	Initial evaluation	The most recent subsequent evaluation
Date of evaluation		
Number of joints with active synovitis		
Health Assessment Questionnaire (HAQ) score		
C reactive protein (CRP) value	_____ mg/L	_____ mg/L
Sedimentation rate value	_____ mm/hr	_____ mm/r
Patient's weight	_____ kg	_____ kg
Return to work, where applicable	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

