



Prior Authorization Request Form

Abatacept (Orencia®), adalimumab (Amgevita®, Hadlima®, Hulio® Humira®, Hyrimoz®, Idacio®), anakinra (Kineret®), baricitinib (Olumiant®), certrolizumabpegol (Cimzia®), etanercet (Enbrel®, Brenzys®, Erelzi®), golimumab (Simponi®), infliximab (Avsola®, Inflectra®, Remicade®, Renflexis™), rituximab (Rituxan®, Truxima®, Riximyo®, Ruxience®), tocilizumab (Actemra®), tofacitinib (Xeljanz®) sarilumab (Kevzara®), upadacitinib (Rinvoq®)/ Rheumatoid polyarthritis

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

Injection – administered at:
 Home Outpatient clinic CHSLD Doctor's office Hospital (patient is admitted) 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**
 Rheumatoid polyarthritis
 Other Specify: _____
Administration of the drug
 Monotherapy
 In conjunction with: _____
 Reason: _____
Evaluation before start of treatment
 Date of evaluation: _____
 Patient's weight: _____ kg
 Number of joints with active synovitis: _____
Please provide at least one of the following:
 Rheumatoid factor Positive Negative
 Erosion is visible on x-rays Yes 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 | Duration of treatment |
| 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 _____ |
| Biologic Agent ⁽¹⁾ Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Biologic Agent ⁽²⁾ Name: _____ Dose: _____ | <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____ | From _____ To _____ |
| Biologic Agent ⁽³⁾ 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: _____

| Information related to the evaluation | First evaluation | Most recent subsequent evaluation |
|---|------------------|--|
| Date of evaluation | | |
| In conjunction with | | |
| 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/hr |
| Patient's weight | _____ kg | _____ kg |
| Return to work, where applicable | N/A | <input type="checkbox"/> Yes <input type="checkbox"/> No |

