



Prior Authorization Request Form

Adalimumab (Amgevita®, Hadlima®, Hulio® Humira®, Hyrimoz®, Idacio®), apremilast (Otezla®), brodulamab (Siliq™), certolizumab pegol (Cimzia®), etanercept (Brenzys®, Enbrel®, Erelzi®), guselkumab (Tremfya™), infliximab (Avsola®, Inflectra®, Remicade®, Renflexis™), ixekizumab (Taltz®), risankizumab (Skyrizi®), secukinumab (Cosentyx®), ustekinumab (Stelara®)
Severe to moderate chronic plaque psoriasis

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 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

- Severe to moderate chronic plaque psoriasis
- Other, specify: _____

Administration of the prescription drug

- Monotherapy (without standard systemic or biologic treatment)
- Other, specify: _____

Evaluation before the start of treatment

Date of evaluation: _____ Patient's weight: _____ kg

DLQI: _____

PASI: _____

OU

- Presence of large lesions on the face, palms, soles or the genital area.
Specify: _____

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Phototherapy Number of treatments: _____	<input type="checkbox"/> Inaccessibility <input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Methotrexate Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Cyclosporine Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____
Acitretin Dose: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication <input type="checkbox"/> Other, specify: _____	From _____ To _____

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

Was a biologic agent previously used to treat psoriasis?

 Yes (please complete information below) No

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
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: _____

	First evaluation	The most recent follow-up evaluation
Date of evaluation	_____	_____
PASI		
DLQI		
Patient's weight	_____ kg	_____ kg
Was there a significant improvement in the lesions on the face, palms, soles or the genital area?	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 8: Additional information
