PRIOR AUTHORIZATION REQUEST FORM

Adalimumab (Amgevita®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®)/ Non-infectious uveitis

DECLARATION OF THE INSURED PERSON

Section 1: Information about the participant and the patient			
Name of participant	Insurance policy / certificate	Name of employer	
Name of patient	Date of birth (YYYY/MM/DD)	Telephone	
Address (house number and street name)	City/Town	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

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DECLARATION OF THE PHYSICIAN

Section 4 : Information about the prescribing physician		
Name of physician	Specialty	Licence 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			
Name of drug	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

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 Non-infectious uveitis ❐ Intermediate uveitis ❐ Posterior uveitis ❐ Panuveitis ❐ Other. Specify: ____

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

Summary of previous trials

❒ Unsatisfactory response to an orally administered corticosteroid for at least 2 weeks (10mg/day or more of prednisone or equivalent).

❒ Patient taking orally administered corticosteroid for at least 4 weeks at a dose equivalent to 10mg per day or more of prednisone and presence of a corticodependence defined as a rebound phenomenon or aggravation of symptoms after withdrawal or cessation is attempted.

❒ Other. Specify:
____
____
____
____

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 (YYYY-MM-DD): _________________

Left eye	Right eye
Vision acuity	
Date (YYYY-MM-DD):______________________ ❒ Stabilization ❒ Improvement ❒ Deterioration	Date (YYYY-MM-DD):______________________ ❒ Stabilization ❒ Improvement ❒ Deterioration
Eye inflammation	
Date (YYYY-MM-DD):______________________ ❒ Stabilization ❒ Improvement ❒ Deterioration	Date (YYYY-MM-DD):______________________ ❒ Stabilization ❒ Improvement ❒ Deterioration

Section 7 : Clinical information (Continuation of treatment) (cont'd)

Orally administered corticosteroids throughout treatment with Adalimumab

❒ None

❒ Reduction in daily dose. Specify:

Name: ____________________

Dose before Adalimumab : _________mg /day

Current dose: _________mg /day

❒ Other. Specify: _____________________________________

Section 8 : Additional information