



PRIOR AUTHORIZATION REQUEST FORM

Abatacept (Orencia®), adalimumab (Amgevita®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®), etanercept (Brenzys®, Enbrel®, Erelzi®), infliximab (Remicade®), / Juvenile idiopathic arthritis of polyarticular or systemic form

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			
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	
What is the status of the prior authorization?	<input type="checkbox"/> Accepted	<input type="checkbox"/> Refused	<input type="checkbox"/> Under review
<i>Please enclose acceptance or refusal documents, if applicable</i>			

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 the 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 the completed form by email or by fax at: 1-855-453-3942.
Telephone: 418-651-2588/1-800-380-2588 – Fax: 1-855-453-3942
Adresse: 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 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	<input type="checkbox"/> First Request Complete section 6		<input type="checkbox"/> Continuation of Treatment Complete section 7 Also, complete section 6 if this is the first authorization requested from SSQ
For Injection – Location where the drug is to be administered: <input type="checkbox"/> Home <input type="checkbox"/> Outpatient <input type="checkbox"/> CHSLD <input type="checkbox"/> Doctor's office <input type="checkbox"/> Patient is hospitalized <input type="checkbox"/> Other. Specify _____ Exact name and address:			

Important:
To ensure sound management of its group insurance plan, SSQ gives preference to the use of biosimilar drugs. The eligibility of claims for brand-name drugs is subject to certain conditions.



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Section 6: Clinical Information (first request)

Evaluation immediately before the start of treatment with the requested drug

Date: _____

Number of joints with active synovitis: _____

Provide at least one of the following

Value of the C-reactive protein _____ mg/l

Value of the sedimentation rate _____ mm/h

Summary of trials with methotrexate

Methotrexate

Dosage: _____ Ineffectiveness Intolerance Contraindication Other from _____

Specify: _____ to _____

Section 6: Clinical Information (continuation of treatment)

Information necessary to evaluate, after five months or more, the response to treatment based on the points evaluated initially

Information related to the evaluation	First evaluation	Most recent evaluation
	Date:	Date:
Number of joints with active synovitis: _____		
Number of joints affected by limitation of movement: _____		
Value of the C-reactive protein	mg/l	mg/l
Value of sedimentation rate	mm/h	mm/h
Score on the pediatric health questionnaire (CHAQ) or a return to school		
Overall evaluation of the physician, the individual or the parent (visual analogue scale)		



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Section 8: Additional information