PRIOR AUTHORIZATION REQUEST FORM
Omalizumab (Xolair®) / Chronic idiopathic urticaria

DECLARATION OF THE INSURED PERSON

Section 1: Information about the plan member and the patient			
Name of plan member	Insurance policy / certificate	Name of employer:	
Name of patient	Date of birth (YYYY/MM/DD)	Telephone	
Address (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 relevant 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 relevant 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.

_____ YYYY-MM-DD

Signature of **patient** (parent/legal guardian) Date

IMPORTANT:

All correspondence concerning this form will be sent to the address indicated in the plan member'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

ssq.ca

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DECLARATION OF THE PRESCRIBER

Section 4: Information about the prescriber		
Name of prescriber	Specialty	License no.
Telephone	Fax	

I hereby certify that the information in this request is complete, true, and accurate.

_____ YYYY-MM-DD

Signature of **prescriber** Date

Section 5: Drug covered by the authorization			
Drug name **Omalizumab (Xolair®)**	Pharmaceutical form Powder for subcutaneous injection	Strength 150 mg/vial	Dose (check) ❒ 150 mg every 4 weeks ❒ 300 mg every 4 weeks
Type of request	❒ First request or first authorization requested from Beneva (SSQ) Complete Section 6	❒ Continuation of treatment Complete Section 7 Also, complete Section 6 if this is the first authorization requested from Beneva (SSQ)	❒ Subsequent request following a relapse after stopping treatment Complete Section 8

For injection – Location where prescription drug is to be administered:

❒ Home ❒ Outpatient ❒ CHSLD ❒ Doctor's office ❒ Hospital

❒ Other. Specify _____

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.

IMPORTANT:
Please do not provide any genetic test results

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Section 6: Clinical information (First request)

Diagnosis

❒ Moderate or severe chronic idiopathic urticaria (CIU)
❒ Other, specify: _____

Please provide the following information:

Urticaria symptoms began on: YYYY-MM-DD

Calculation of UAS7 (Weekly Urticaria Activity Score) and ISS (Itching Severity Score)

Evaluation period from YYYY-MM-DD to YYYY-MM-DD

Current treatment: Drug _____

Dose _____

	24-hr Evaluation	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Total
Number of hives	None	0	0	0	0	0	0	0	/21
	1-6	1	1	1	1	1	1	1	
	7-12	2	2	2	2	2	2	2	
	> 12	3	3	3	3	3	3	3	
Itchiness	None	0	0	0	0	0	0	0	/21 (ISS)
	Mild	1	1	1	1	1	1	1	
	Moderate	2	2	2	2	2	2	2	
	Severe	3	3	3	3	3	3	3	
Total									/42 (UAS7)

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**
Name: _____________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____________	from YYYY-MM-DD to YYYY-MM-DD
Name: _____________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____________	from YYYY-MM-DD to YYYY-MM-DD
Name: _____________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____________	from YYYY-MM-DD to YYYY-MM-DD
Name: _____________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____________	from YYYY-MM-DD to YYYY-MM-DD

Section 7: Clinical information (continuation of treatment after 24 weeks)
Information necessary to assess the response to treatment
The drug covered by the present authorization request was first taken on: YYYY-MM-DD
❒ Full response over a period of less than 12 weeks (UAS7 ≤ 6) ❒ Partial response (drop in UAS7 score of at least 9.5 points since the start and UAS7 > 6) ❒ Other. Specify: ____

Section 7: Clinical information (continuation of treatment after 24 weeks)	
UAS7 scores providing the evidence of the observed response	
UAS7 score – Starting value Date: YYYY-MM-DD	Score: _____
UAS7 score – Value during treatment Date: YYYY-MM-DD	Score: _____
UAS7 score – Value during treatment Date: YYYY-MM-DD	Score: _____
UAS7 score – Value during treatment Date: YYYY-MM-DD	Score: _____
UAS7 score – Value during treatment Date: YYYY-MM-DD	Score: _____
UAS7 score – Value during treatment Date: YYYY-MM-DD	Score: _____
Any other relevant UAS7 score objectifying the response. Date: YYYY-MM-DD	Score: _____

Section 8: Clinical information (request following a relapse after stopping treatment)

Indication for re-treatment

❒ Relapse following a prior satisfactory treatment

❒ Other, specify: _____

Prior treatment

Date of the last Xolair® injection: _____

Response: ❒ Complete ❒ Other. Specify: _____

UAS7 score following the last injection: _____ Date: YYYY-MM-DD

Current UAS7 score indicating a relapse*: _____ Date: YYYY-MM-DD

*Relapse is defined by RAMQ as the attainment of a UAS7 score equal to or greater than 16 following a complete response.

Section 9: Additional information