PRIOR AUTHORIZATION REQUEST FORM
Faricimab-Svoa (Vabysmo®) /
Diabetic Macular Edema (DME)

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 (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 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

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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 **Vabysmo**	Pharmaceutical form	Strength	**Dosage:** Dose: _____ Frequency: _____

IMPORTANT:
Please do not provide any genetic test results

Section 6 : Clinical information

Therapeutic indication

❒ Diabetic Macular Edema (DME)

❒ Other. Specify: _____

Left eye	Right eye
Administration of the drug covered by the authorization	
❒ Monotherapy ❒ In conjunction: Specify agent: _____	❒ Monotherapy ❒ In conjunction: Specify agent: _____
Thickness of the central retina	
❒ ≥ 250µm ❒ Other. Specify: _____	❒ ≥ 250µm ❒ Other. Specify: _____

Section 7: Additional information

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