PRIOR AUTHORIZATION REQUEST FORM
Atogepant (Qulipta®), Eptinezumab (Vyepti®), Erenumab (Aimovig®), Fremanezumab (Ajovy®), Galcanezumab (Emgality®), OnabotulinumtoxinA, botulinum toxin type A (Botox®) / Migraines

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.

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

PRIOR AUTHORIZATION REQUEST FORM
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DECLARATION OF THE PRESCRIBER

Section 4: Information about the prescriber		
Name of prescriber	Specialty	Licence No.:
Telephone	Fax	
I hereby certify that the information in this request is complete, true, and accurate: Signature of **prescriber** _____ Date _____		

Section 5 : Drug covered by the authorization			
Drug name	**Pharmaceutical form**	**Strength**	**Dosage**
❒ Atogepant (Qulipta®)	Oral tablets	10 mg 30 mg 60 mg	Dose: _____ Frequency of administration: _____
❒ Eptinezumab (Vyepti®)	Intravenous solution	100 mg/ml	Dose: _____ Frequency of administration: _____
❒ Erenumab (Aimovig®)	Subcutaneous solution	70 mg 140 mg	Dose: _____ Frequency of administration: _____
❒ Fremanezumab (Ajovy®)	Subcutaneous solution	225 mg	Dose: _____ Frequency of administration: _____
❒ Galcanezumab (Emgality®)	Subcutaneous solution	120 mg/mL	Dose: _____ Frequency of administration: _____
❒ Onabotulinumtoxin A, Botulinum toxin type A (Botox®)	Powder for IM injection	50 IU 100 IU 200 IU	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.

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Injection – administered at:

❒ Home ❒ Outpatient clinic ❒ CHSLD

❒ Doctor's office ❒ Hospital (patient is admitted) ❒ Other Specify_____

Exact location's name and address:

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

Section 6 : Clinical information (first request)

Diagnosis

❒ Episodic migraine

❒ Chronic migraine

❒ Other. Specify: _____

Onset of symptoms date: _____

Fill in the necessary information

Result on HIT-6 Migraine scale	
Number of days with migraine (per month)	

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Tricyclic antidepressant: Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify:_____	From _____ To _____
Anticonvulsant: Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify:_____	From _____ To _____
Antihypertensive: Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify:_____	From _____ To _____

Other: Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify:_____	From _____ To _____
Other: Name: _____ Dose: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ 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 (YYYY-MM-DD): _____

Information required to assess the response to treatment with respect to the first evaluation

	Initial evaluation	**Last evaluation**
Date	YYYY-MM-DD	YYYY-MM-DD
Result on HIT-6 Migraine scale		
Number of days with migraine (per month)		

Section 8 : Additional information