PRIOR AUTHORIZATION REQUEST FORM
Aflibercept (Eylea®), Ranibizumab (Byooviz®, Lucentis®) / Neovascular (wet) age-related macular degeneration (AMD)

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

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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			
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.

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IMPORTANT:
Please do not provide any genetic test results

Section 6: Clinical information (first request)

Therapeutic indication

❒ Neovascular (wet) age-related macular degeneration (AMD)

❒ Other. Specify: _____

Left eye	Right eye
Administration of requested prescription drug	
❒ Monotherapy ❒ In conjunction with Specify the agent: _____	❒ Monotherapy ❒ In conjunction with Specify the agent: _____
Optimum visual acuity after correction	
❒ Between 6/12 and 6/96 ❒ Other. Specify: _____	❒ Between 6/12 and 6/96 ❒ Other. Specify: _____
Linear dimension of the lesion	
❒ ≤ 12 disc surfaces ❒ Other. Specify: _____	❒ ≤ 12 disc surfaces ❒ Other. Specify: _____
State of the centre of the macula	
❒ No significant permanent structural damage* ❒ Other. Specify: _____	❒ No significant permanent structural damage* ❒ Other. Specify: _____
*The damage is defined as fibrosis, atrophy or chronic disciform scarring, the seriousness of which prevents obtaining a functional benefit according to the attending physician	
Evolution of the illness over the past 3 months confirmed by:	
❒ Retinal angiography ❒ Optical coherence tomography ❒ Recent visual acuity change ❒ Other. Specify: _____	❒ Retinal angiography ❒ Optical coherence tomography ❒ Recent visual acuity change ❒ 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
Response to treatment	
❒ Stabilization ❒ Improvement ❒ Deterioration	❒ Stabilization ❒ Improvement ❒ Deterioration
Medical exam used	
Date: _____ ❒ Retinal angiography ❒ Optical coherence tomography ❒ Other. Specify: _____	Date: _____ ❒ Retinal angiography ❒ Optical coherence tomography ❒ Other. Specify: _____

Section 8: Additional information