PRIOR AUTHORIZATION REQUEST FORM
Alirocumab (Praluent®), evolocumab (Repatha®), inclisiran (Leqvio®) / Hyperlipidemia

DECLARATION OF THE INSURED PERSON

Section 1 : Information about the plan member and the patient			
Name of plan member	Policy / Certificate	Name of employer:	
Name of patient	Date of birth (YYYY/MM/DD)	Telephone	
Address (number and street name)	Town/City	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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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	**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

In compliance with Health Canada indication:

❒ **Primary Hyperlipidemia**

For informational purposes only:

Praluent, Repatha and Leqvio are indicated for the reduction of elevated low density lipoprotein cholesterol (LDL-C) in adult patients with primary hyperlipidemia (including heterozygous familial hypercholesterolemia).

REPATHA is indicated as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) in adult patients and adolescent patients aged 12 years and over with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C.

❒ **Prevention of cardio-vascular events for adult patients with atherosclerotic cardiovascular disease (ASCVD)**:

- ❒ Not clinically manifested
  - Specify: _____
- ❒ Clinically manifestated
  - ❒ Stable/unstable angina
  - ❒ Myocardial infarction
  - ❒ Stroke
  - ❒ Other, specify: _____

❒ Other, specify diagnosis: _____

Administration of the prescription drug covered by the authorization

❒ As primary prevention

❒ As secondary prevention

❒ Monotherapy

❒ In conjunction with other treatment

Please specify:

_____

Section 6 – Clinical information (first request) (cont'd)

Lipid Profile Results

At the diagnosis:

Evaluation Date (AAAA-MM-JJ) : _____

Total Cholesterol : _____ mmol/l

LDL-C : _____ mmol/l

HDL-C : _____ mmol/l

Apo-B : _____ mg/l

Before the treatment start with alirocumab or evolocumab or inclisiran

Evaluation Date (AAAA-MM-JJ) : _____

Total Cholesterol : _____ mmol/l

LDL-C : _____ mmol/l

HDL-C : _____ mmol/l

Apo-B : _____ mg/l

Summary of previous trials or contraindications

Drug or other medical treatment	Reason for discontinuation	Duration of treatment
Statin (1) Name: _____ Dosage: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Statin (2) Name: _____ Dosage: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Statin (3) Name: _____ Dosage: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD

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**
Fibrates Name: _____ Dosage: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Bile-acid sequestrants Name: _____ Dosage: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Ezetimibe Name: _____ Dosage: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD
Other agent Name: _____ Dosage: _____	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other, specify: _____	From YYYY-MM-DD To YYYY-MM-DD

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): YYYY-MM-DD

Information necessary to evaluate the response to treatment		
	Result before starting the biological agent	**Last result**
Lipid profile	Date: YYYY-MM-DD	Date: YYYY-MM-DD
Chol total	Value: _____mmol/L	Value: _____mmol/L
LDL-C	Value: _____mmol/L	Value: _____mmol/L
HDL-C	Value: _____mmol/L	Value: _____mmol/L
Apo-B	Value: _____mg/L	Value: _____mg/L

Section 8 :Additional information