PRIOR AUTHORIZATION REQUEST FORM
EXCEPTIONAL PATIENT

DECLARATION OF THE INSURED PERSON

Section 1: Information about the participant and the patient			
Name of participant	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 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 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 participant'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

PRIOR AUTHORIZATION REQUEST FORM
EXCEPTIONAL PATIENT

DECLARATION OF THE PHYSICIAN

Section 4 : Information about the prescribing physician		
Name of physician	Specialty	Licence No.:
Telephone	Fax	
I hereby certify that the information in this request is complete, true and accurate: Signature of **physician** _____ 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
Injection – administered at: ❒ Home ❒ Outpatient clinic ❒ CHSLD ❒ Doctor's office ❒ Hospital (patient is admitted) ❒ Other Specify_____ Exact location's name and address:			

Section 6 : Clinical information (first request)
Diagnosis Other. Specify: _____ Onset of symptoms date (YYYY-MM-DD): _____

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

Lab test results pertinent to the processing of this request BEFORE the requested treatment began (e.g., Hb, LDL-Chol, etc.)

Lab test	Results	Date (YYYY-MM-DD)

Results on a widely used scale for assessing the severity of the condition BEFORE the start of requested treatment (e.g., DLQI, HAQ, ECOG, etc.)

Scale	Results	Date (YYYY-MM-DD)

Clinical test results pertinent to the assessment of this request BEFORE the start of requested treatment (e.g., imagery, investigation report, etc.)

Tests	Results	Date (YYYY-MM-DD)

Does this condition have known physical or psychological functional repercussions on the person's regular activities?

- ❒ No
- ❒ Yes. Complete the table below (if the treatment has begun, answer based on the person's condition prior to the start of treatment)

Activity	Impairment*
Physical activities (walking, walking up the stairs, lifting an object or other)	
Daily activities at home (personal hygiene, meal preparation, housecleaning or other)	
Daily activities outside of the home (paid or unpaid work, attending school, errands, leisure activities, sports or other)	
Social activities (meal at a restaurant, movies, visits to family, volunteering or other)	

* 0 = No impairment 1 = Light impairment 2 = Moderate impairment 3 = Severe impairment 4 = Extreme impairment

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 ___________ To ______________
Name: ________________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other. Specify: ______________________________	From ___________ To ______________
Name: ________________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other. Specify: ______________________________	From ___________ To ______________
Name: ________________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other. Specify: ______________________________	From ___________ To ______________
Name: ________________ Dose: _____________	❒ Ineffectiveness ❒ Intolerance ❒ Contraindication ❒ Other. Specify: ______________________________	From ___________ To ______________

Describe all other known effective medication or medical treatments for this condition that cannot be prescribed due to the patient's specific clinical conditions:

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): _____

Comparison of lab test results pertinent to the processing of this request **BEFORE** and **AFTER** the requested treatment began (e.g., Hb, LDL-Chol, etc.)

Lab test	Initial evaluation	Most recent evaluation
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____

Comparison of the results on a widely used scale for assessing the severity of the condition **BEFORE** and **AFTER** the requested treatment began (e.g., DLQI, HAQ, ECOG, etc.)

Scale	Initial evaluation	Most recent evaluation
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____
	Result : _____ Date : _____	Result : _____ Date : _____

Section 7 : Clinical information (continuation of treatment) (cont'd)		
Recent clinical test results pertinent to the assessment of the response to treatment (e.g., imagery)		
Clinical test	**Results**	**Date** (YYYY-MM-DD)

Other benefits observed since the start of treatment:

Section 8 : Additional information