Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com/planmember
Tel.: 1-844-410-6485
Fax: 1-877-838-2134
418-838-2134

PRIOR AUTHORIZATION REQUEST
CANCER DRUGS

PLEASE READ THE INSTRUCTIONS ON THE LAST PAGE OF THIS FORM.

A PATIENT IDENTIFICATION – To be completed by the member.

Patient's last and first name | Relationship with member ☐ Member ☐ Spouse ☐ Dependent child | Patient's date of birth YYYY MM DD

Member's last and first name | Contract No. | Certificate No.

No., street, apt. | City | Province | Postal code

Telephone Nos – Home: | Office: | Extension: | Email:

Since the response to this request includes confidential information, please indicate how you would like to be informed of the decision:

☐ By mail (The response to your request will be sent to the address indicated in this section.) ☐ By fax: _____

Coordination of benefits: If the patient has coverage under a private insurance plan or is enrolled in a provincial drug insurance plan, please submit the request to this plan first. Then send us a copy of the decision notice and this form filled out by the physician, so we can analyze the request.

PRIVATE PLAN

Does the patient have drug coverage under a private insurance plan?

☐ **Yes** – Please provide a copy of the notice of approval or refusal. → ☐ **Copy attached to this form.**

Specify: Name of the insurer: _____ Contract No.: _____ Certificate No.: _____

☐ **No**

PROVINCIAL PLAN

Has a request for reimbursement been submitted under your provincial plan?

☐ **Yes** – Please provide a copy of the notice of approval or refusal. → ☐ **Copy attached to this form.**

☐ **No** – Please explain: _____

PATIENT SUPPORT PROGRAM

Is the patient enrolled in a patient support program? ☐ **Yes** ☐ **No**

If so – Program name: _____

Contact person: _____ Telephone No.: _____ Extension: _____

B1 DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the claim form is accurate and complete. I authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, strictly for the purposes of managing my file and settling this claim to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, and insurance companies; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary use the personal information it may have about me in existing files that are now closed. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of member: _____ **Date:** _____

Last name and first name of parent/legal guardian (if applicable): _____

Signature of patient or parent/legal guardian (if applicable): _____ **Date:** _____

B2 CONSENT TO THE COMMUNICATION OF PERSONAL INFORMATION TO A THIRD PARTY

To help us process your claim more efficiently, do you authorize Desjardins Insurance to inform the patient support program and the attending physician or the attending physician's medical team of the reasons for the decision on your prior authorization request?

☐ Yes ☐ No

Signature of member: _____ **Date:** _____

Last name and first name of parent/legal guardian (if applicable): _____

Signature of patient or parent/legal guardian (if applicable): _____ **Date:** _____

C ATTENDING PHYSICIAN SECTION – To be completed by the attending physician.

Physician's last and first name (PLEASE PRINT) | License No. | Specialty

No., street, suite | City | Province | Postal code

Telephone No.: | Fax No.:

Signature of physician: **Date:**

Drug name	Formulation	Strength	Dosage	Patient's weight	Scheduled duration of treatment

Where is the drug administered? ☐ Home ☐ Physician's office ☐ Private clinic ☐ Hospital – Inpatient ☐ Hospital – Outpatient

☐ Other (please specify): _____

PRINT NEW REQUEST

C ATTENDING PHYSICIAN SECTION – Continued

- **Make sure to fill out all sections so we can process the request faster. If any information is missing, we will send the form back to the member.**
- **In order to consider any diagnosis not mentioned on this form, we need supporting documents (clinical practice guidelines, clinical studies, etc.) that justify the drug's use in the given context.**

DIAGNOSIS

Caprelsa: ☐ Symptomatic or progressive medullary thyroid cancer
Is the patient eligible to the Caprelsa restricted distribution program? ☐ Yes ☐ No

Cotellic: ☐ Unresectable or metastatic melanoma with BRAF V600 mutation
Was the BRAF V600 mutation status identified with a validated test? Please specify: _____

Cyramza: ☐ Gastric cancer ☐ As monotherapy ☐ In combination with paclitaxel - ECOG performance status: _____

Gazyva: ☐ Chronic lymphocytic leukemia

Hycamtin: ☐ Small cell lung cancer ☐ Metastatic carcinoma of the ovary Neutrophil count: _____ /L)

Iclusig: ☐ Chronic myeloid leukemia ☐ Philadelphia chromosome positive acute lymphoblastic leukemia

Nexavar: ☐ Unresectable hepatocellular carcinoma (HCC) ☐ Locally advanced or metastatic renal cell carcinoma
☐ Locally advanced or metastatic differentiated thyroid carcinoma Is the disease in progression? ☐ Yes ☐ No

Sutent: ☐ Gastrointestinal stromal tumour ☐ Pancreatic neuroendocrine tumour
☐ Metastatic renal adenocarcinoma: Is the carcinoma of clear cell histology? ☐ Yes ☐ No

Patient's ECOG* performance status: _____ *ECOG = Eastern Cooperative Oncology Group

Tarceva: ☐ Non-small cell lung cancer (second line therapy)
☐ Non-small cell lung cancer (as monotherapy for maintenance treatment)
☐ Non-small cell lung cancer (as monotherapy for first-line treatment)
} Patient's ECOG performance status: _____

Temodal: ☐ Anaplastic astrocytoma ☐ Glioblastoma multiforme (GBM) Will the treatment be administered in combination with radiotherapy? ☐ Yes ☐ No
☐ Malignant melanoma with brain metastases

Tykerb: ☐ Metastatic breast cancer whose tumor overexpresses HER2 Menopausal woman: ☐ Yes ☐ No
Patient's ECOG performance status: _____ Candidate for hormone therapy: ☐ Yes ☐ No
Is the cancer hormone receptor positive? ☐ Yes ☐ No
Candidate to Herceptin (trastuzumab): ☐ Yes ☐ No In association with: ☐ Letrozole ☐ Capecitabine

Votrient: ☐ Metastatic renal cell (clear cell carcinoma) (MRCC) _____ first line therapy _____ second line therapy
☐ Adult patient with selective subtypes of advanced Soft Tissue Sarcoma

Zelboraf: ☐ BRAF V600 mutation-positive unresectable or metastatic melanoma Patient's ECOG performance status: _____

Zolinza: ☐ Advanced cutaneous T-cell lymphoma (CTCL)

PRIOR MEDICATION OR TREATMENT

Has the patient ever used medication or received treatment for this medical condition? ☐ Yes ☐ No

If not, please explain: _____

If so, please list any medication already used or any treatment already received for this medical condition:

MEDICATION OR TREATMENT NAME	OUTCOME	TREATMENT PERIOD
Name:	☐ Inefficiency ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD
Name:	☐ Inefficiency ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD
Name:	☐ Inefficiency ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD
Name:	☐ Inefficiency ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD

C ATTENDING PHYSICIAN SECTION – Continued

PRESCRIPTION RENEWAL

Please provide objective data that shows a satisfactory clinical or biological response: _____

_____

_____

D INSTRUCTIONS – HOW TO COMPLETE AND RETURN THIS FORM

1. Complete sections A and B.
2. Ask your physician to complete section C. The member is responsible for assuming any costs incurred to complete this form or to obtain additional information.
3. To obtain a reimbursement once the drug has been approved, please use your payment card at the pharmacy or submit your original receipts by mail. Eligible drugs must be dispensed by a pharmacist or a physician, if there is no pharmacist.
4. Send form:
   - by fax: Desjardins Insurance
     Group Insurance, Health Claims,
     418-838-2134 or 1-877-838-2134 (toll-free)
   - by mail: Desjardins Insurance
     Group Insurance, Health Claims
     C. P. 3950, Lévis (Québec) G6V 8C6

Under its prior authorization program, Desjardins Insurance authorizes the reimbursement of certain drugs that meet criteria that are based, in particular, on clinical practice guidelines and recommendations issued by health technology assessment organizations. The drug will be eligible for reimbursement if it meets the insurer's criteria, if it's not administered in a hospital and if it's not eligible under a government program. If the information on your form is complete, your request will normally be processed within 5 business days.

When the request form is received, it will be assessed in the strictest confidence. In some situations, additional diagnostic or clinical information may be required.

If the treatment continues beyond the authorized period, you will be asked to submit a new request form and provide information that justifies the extension of treatment. If you have a payment card, your pharmacist will be advised that the authorization period is coming to an end. The insurance must be in force and the patient still covered on the date expenses are incurred. This prior authorization is subject to change if, at the time expenses are incurred, the contract has been modified.

When Desjardins Insurance declines a prior authorization request, it is because we need to uphold conditions set out in the contract. It does not mean we are questioning the physician's opinion. If you have any questions, please contact our Customer Contact Centre at the number indicated on page 1 of this form.