





AUBAGIO (TERIFLUNOMIDE)      KESIMPTA (OFATUMUMAB)  
 AVONEX (INTERFERON BETA-1A)    PLEGRIDY (PEGINTERFERON BETA-1A)  
 BETASERON (INTERFERON BETA-1B)    REBIF (INTERFERON BETA-1A)  
 EXTAVIA (INTERFERON BETA-1B)    TECFIDERA (DIMETHYL FUMARATE)

**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 <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> 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.**

<b>PRIVATE PLAN</b>	Does the patient have drug coverage under a private insurance plan? <input type="checkbox"/> Yes – Please provide a copy of the notice of approval or refusal. → <input type="checkbox"/> Copy attached to this form. Specify: Name of the insurer: _____ Contract No.: _____ Certificate No.: _____ <input type="checkbox"/> No
<b>PROVINCIAL PLAN</b>	Has a request for reimbursement been submitted under your provincial plan? <input type="checkbox"/> Yes – Please provide a copy of the notice of approval or refusal. → <input type="checkbox"/> Copy attached to this form. <input type="checkbox"/> No – Please explain: _____
<b>PATIENT SUPPORT PROGRAM</b>	Is the patient enrolled in a patient support program? <input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_

**CONTINUED ON THE BACK**

**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	Scheduled duration of treatment
Where is the drug administered? <input type="checkbox"/> Home <input type="checkbox"/> Physician's office <input type="checkbox"/> Private clinic <input type="checkbox"/> Hospital – Inpatient <input type="checkbox"/> Hospital – Outpatient				
<input type="checkbox"/> Other (please specify): _____				

- 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**
 First acute clinical demyelinating event     Relapsing-remitting multiple sclerosis     Secondary progressive multiple sclerosis

 Other therapeutic indication(s) – Please specify: \_\_\_\_\_
**Information relating to first acute clinical episode of demyelination**
 Presence of at least one asymptomatic hyperintense lesion on T2 in the following regions:     Periventricular     Juxtacortical     Infratentorial     Spinal cord

Diameter of the largest region: \_\_\_\_\_ Expanded Disability Status Scale (EDSS) score: \_\_\_\_\_

**Information relating to remitting multiple sclerosis and secondary progressive multiple sclerosis**

How many clinical relapses has the patient experienced? \_\_\_\_\_ Dates at which the two last relapses occurred: \_\_\_\_\_

 Objective clinical evidence of 1, 2 or more lesions characteristic of multiple sclerosis:     0     1     2 or more

 Presence of at least 1 hyperintense lesion T2 in the following areas:     Periventricular     Juxtacortical     Infratentorial     Spinal cord

 Simultaneous presence of Gadolinium-enhanced lesions and non-enhanced lesions:     Yes     No

 Presence of a new T2 hyperintense lesion or Gadolinium-enhanced lesion compared to the previous exam:     Yes     No

Expanded Disability Status Scale (EDSS) score: \_\_\_\_\_

**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: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From:    YYYY   MM   DD
Dose: _____	Specify: _____	To:    YYYY   MM   DD
Name: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From:    YYYY   MM   DD
Dose: _____	Specify: _____	To:    YYYY   MM   DD
Name: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From:    YYYY   MM   DD
Dose: _____	Specify: _____	To:    YYYY   MM   DD
Name: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From:    YYYY   MM   DD
Dose: _____	Specify: _____	To:    YYYY   MM   DD

Is the patient severely intolerant or is there a contra-indication to the following treatments:

 Interferon beta     Glatiramer     Teriflunomide     Natalizumab     Dimethyl Fumarate

Please specify: \_\_\_\_\_

