Desjardins Insurance
Life • Health • Retirement

Information and consent for the patient support program for specialty drugs

Please fill out this page only if you live outside Quebec.

INFORMATION

The prescription drug that is the object of your request is part of our patient support program. Designed to help you better manage your medical condition, this program provides you with many benefits such as access to professional support from a team of pharmacists. For more information, see the *Prior Authorization Drugs and the Patient Support Program* brochure, available at www.desjardinslifeinsurance.com/PAD.

If your contract includes the program, you may be required to participate.

A healthcare professional from the provider selected by Desjardins Insurance will contact you to let you know the status of your request, to explain how the program works and to direct you to a preferred pharmacy. That professional may also contact your attending physician to get any missing information. The information obtained as a result of this prior authorization request will be sent to the third party and used to process your request. This is why your signature is required.

IMPORTANT

As part of the patient support program, you will be reimbursed for your specialty drug only if you purchase it through the preferred pharmacy network.

CONSENT TO DISCLOSE TO A THIRD PARTY

For the sole purpose of the patient support program, I authorize Desjardins Insurance to disclose to the third party personal information about me, especially my medical information, that is needed for the program. I understand that the third party may share this information with my doctors, pharmacists and other healthcare professionals as part of this program.

This consent also applies to the disclosure of personal information concerning my dependents, insofar as this request involves them.

Last name and first name of the member (PLEASE PRINT) Contract No. Certificate No.

Email address of the member

Signature of the member Date

Last name and first name of the parent or legal guardian (if necessary)

Signature of the parent or legal guardian (if necessary) Date

This consent is an integral part of the attached Prior Authorization Request form.

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

COPAXONE (GLATIRAMER ACETATE)
GLATECT (GLATIRAMER ACETATE)

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	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.**

Requests for treatment with COPAXONE will only be considered in exceptional cases, since a subsequent entry non-biologic complex drug, GLATECT, is available on the market. If the patient's situation doesn't allow them to transition to GLATECT, indicate the reason below:

☐ **Pregnant patient – Due date:** YYYY-MM-DD

☐ **Pediatric patient**

☐ **Other – Please provide sufficiently documented medical justification.**

Diagnosis

☐ First acute clinical demyelinating event ☐ Relapsing-remitting multiple sclerosis

☐ Other therapeutic indication(s) – Please specify:

Information relating to first acute clinical episode of demyelinization

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

How many clinical relapses has the patient experienced? _____

Dates at which the two last relapses occured: _____ _____

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:	☐ 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

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

☐ Interferon beta ☐ Teriflunomide ☐ Natalizumab ☐ Dimethyl Fumarate

Please specify: _____

PRESCRIPTION RENEWAL

Number of clinical relapses in the past year: _____

Expanded Disability Status Scale (EDSS) score: _____

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.