Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com/planmember
1-844-410-6485

PRIOR AUTHORIZATION REQUEST
ULTOMIRIS (RAVULIZUMAB)
SOLIRIS (ECULIZUMAB)

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

☐ Paroxysmal nocturnal hemoglobinuria (PNH) ☐ Atypical hemolytic uremic syndrome (aHUS)

☐ Other therapeutic indication(s) – Please specify:

INFORMATION RELATING TO PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)

Please provide serum concentration of lactate dehydrogenase (LDH): _____

Please indicate serum concentration of hemoglobin: _____

Please indicate if one of the following applies to the patient:

☐ Thrombotic or embolic event which required institution of therapeutic anticoagulant therapy

☐ Minimum transfusion of 4 units of red blood cells in the previous 12 months

☐ Anemia defined by a hemoglobin serum concentration measured at least twice, < 100 g/L and accompanied by symptoms of anemia, or ≤ 70 g/L

☐ Pulmonary insufficiency: debilitating shortness of breath and/or chest pain resulting in limitation of normal activity

☐ Renal insufficiency demonstrated by an eGFR less than or equal to 60mL/min

☐ Smooth muscle spasm: recurrent episodes of severe pain requiring hospitalization and/or narcotic analgesia

INFORMATION RELATING TO ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)

Please indicate ADAMTS-13 activity: _____

Please indicate result for the STEC (Shiga toxin-producing E.Coli)-test: _____

Please indicate result for the platelet count: _____

Please indicate what situation apply to the patient:

☐ Presence of schistocytes ☐ Lactate dehydrogenase above normal range

☐ Low or absent haptoglobin ☐ Tissue biopsy confirming TMA

Please provide one of the following: eGFR: _____ Creatinine clearance: _____

Please indicate if one of the following documented clinical features of active organ damage or impairment other than renal impairment (neurological, cardiac, pulmonary, gastro-intestinal): _____

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

PRESCRIPTION RENEWAL – Please provide an objective evidence of efficacy.

Paroxysmal nocturnal hemoglobinuria

Please indicate serum concentration of lactate dehydrogenase (LDH): _____ LDH concentration before treatment: _____

Atypical hemolytic uremic syndrome

Please provide the following: Platelet count: _____ Haptoglobin count: _____

Serum concentration of lactate dehydrogenase (LDH): _____

Please provide the following information: eGFR: _____ Baseline eGFR: _____

If one of the following complications was present at initiation of treatment, please indicate which impairment was stabilized with eculizumab:

☐ Not applicable ☐ Cardiac ☐ Neurologic ☐ Pulmonary ☐ Gastro-intestinal

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.