Desjardins Insurance
Life • Health • Retirement

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

PRIOR AUTHORIZATION REQUEST

JUXTAPID (LOMITAPIDE)
LEQVIO (INCLISIRAN)
PRALUENT (ALIROCUMAB)
REPATHA (EVOLOCUMAB)

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:**

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	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):

- **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.**

Clinical atherosclerotic cardiovascular disease : We are not accepting requests for Juxtapid, Leqvio, Praluent and Repatha for this diagnosis.
Heterozygous familial hypercholesterolemia (HeFH) : We are not accepting requests for Juxtapid for this diagnosis.
Homozygous familial hypercholesterolemia (HoFH) : We are not accepting requests for Praluent for this diagnosis.
We will consider requests for Juxtapid for this diagnosis only if there has already been an adequate trial with Repatha, along with a diet and other lipid-lowering treatments (statins, ezetimibe and LDL apheresis).

DIAGNOSTIC

☐ Homozygous familial hypercholesterolemia (HoFH) ☐ Heterozygous familial hypercholesterolemia (HeFH)
☐ Other therapeutic indication(s) – Please specify:

INFORMATION RELATING TO HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HoFH)

The treatment will be administered in combination with other lipid-lowering treatments: ☐ Yes ☐ No
Until now, the patient has been on a low-cholesterol diet: ☐ Yes ☐ No
For **at least three months** before the start of treatment, the patient's LDL cholesterol was above 2 mmol/L despite taking two or more statins: ☐ Yes ☐ No
Will the treatment be administered in combination with a low-density lipoproteins (LDL) apheresis treatment? ☐ Yes ☐ No
If not, please specify the reason:
The patient has one or more functional mutations in both LDL receptor alleles or alleles known to affect LDL receptor functionality: ☐ Yes ☐ No
The patient's LDL cholesterol was above 13 mmol/L before treatment: ☐ Yes ☐ No
The patient had xanthomas before age 10: ☐ Yes ☐ No
Both biological parents have been diagnosed with heterozygous familial hypercholesterolemia (HeFH): ☐ Yes ☐ No

INFORMATION RELATING TO HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH)

Does the patient have atherosclerotic cardiovascular disease? ☐ Yes – specify: _____ ☐ No

LDL-C at the time of diagnosis: _____ mmol/L Date: _____

LDL-C before the start of the requested treatment: _____ mmol/L Date: _____

Please check any element that apply to the patient:

☐ DNA-based evidence of an LDL receptor mutation or other FH-related gene mutation

☐ Family history of HeFH, confirmed by genotyping, in a first degree relative

☐ Presence of a mutation causing familial hypercholesterolemia of LDLR, ApoB or PCSK9 genes in a first-degree relative

☐ Presence of xanthomas in the person or in one of the parents of the first or second degree

☐ Presence of an arcus cornealis before the age of 45 in a first degree relative

☐ Family history of LDL-C > 4.9 mmol/L in an adult first degree relative or ≥ 4 mmol/L in a first degree relative younger than 18 years of age

☐ Family history of a total cholesterol concentration > 7.5 mmol/L in a first- or second-degree adult parent or > 6.7 mmol/L in a first-degree parent under 16 years of age

PRINT NEW REQUEST

C ATTENDING PHYSICIAN SECTION – Continued

PRIOR MEDICATION OR TREATMENT

Intolerance to two or more statins as shown by the following (check all applicable boxes):

☐ Myopathy or myalgia (muscle pain, pain or weakness without CK elevation)

☐ Myositis (muscle pain with CK elevation)

☐ Rhabdomyolysis (muscle pain with marked CK elevation)

Past and present therapy (statins, ezetimibe, etc.)	Dose	Start date YYYY MM DD	End date YYYY MM DD	Outcome (provide details of intolerance, contraindication, or failure at maximum dose)	Will this therapy be continued in addition to the new drug requested?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

PRESCRIPTION RENEWAL

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

LDL cholesterol testing must have been done within three months of this request:

Baseline date YYYY MM DD	Baseline measure before starting requested drug	Follow-up date YYYY MM DD	Follow-up measure	Follow-up date YYYY MM DD	Follow-up measure

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.