

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](http://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.**



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: \_\_\_\_\_

**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
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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.

**Diagnosis**

- Systemic juvenile idiopathic arthritis     
  Polyarticular juvenile idiopathic arthritis     
  Psoriatic arthritis of the rheumatoid type  
 Psoriatic arthritis other than the rheumatoid type     
  Rheumatoid arthritis     
  Ankylosing spondylitis  
 Crohn's disease     
  Fistulising Crohn's disease     
  Ulcerative colitis     
  Psoriasis  
 Other therapeutic indication(s) – Please specify: \_\_\_\_\_

**Information relating to polyarticular or systemic juvenile idiopathic arthritis**

Number of joints with active synovitis: \_\_\_\_\_

Childhood Health Assessment Questionnaire (CHAQ) score: \_\_\_\_\_

Please provide at least one of the following pieces of information: C-reactive protein value: \_\_\_\_\_ mg/L

Erythrocyte sedimentation rate value: \_\_\_\_\_ mm/hr

**Information relating to rheumatoid arthritis or psoriatic arthritis**

Number of joints with active synovitis: \_\_\_\_\_

**Please provide at least one of the following pieces of information:**

Presence of a positive rheumatoid factor:  Yes  No      C-reactive protein value: \_\_\_\_\_ mg/L

Presence of radiological erosions:  Yes  No      Erythrocyte sedimentation rate value: \_\_\_\_\_ mm/hr

Health Assessment Questionnaire (HAQ) result: \_\_\_\_\_

**Information relating to ankylosing spondylitis**

BASDAI test result: \_\_\_\_\_      Degree of functional impairment according to the BASFI (scale of 0 to 10): \_\_\_\_\_

(BASDAI = Bath Ankylosing Spondylitis Disease Activity Index)      (BASFI = Bath Ankylosing Spondylitis Functional Index)

**Information relating to Crohn's disease** – Harvey Bradshaw Index (HBI) score: \_\_\_\_\_

**Information relating to ulcerative colitis**

Mayo score: \_\_\_\_\_      Mayo endoscopic subscore: \_\_\_\_\_      Mayo rectal bleeding subscore: \_\_\_\_\_

**Information relating to psoriasis**

Presence of significant patches:  Face     Hands     Feet     Genital region

Psoriasis Area Severity Index (PASI) result: \_\_\_\_\_

Dermatology Life Quality Index (DLQI) Evaluation Questionnaire result: \_\_\_\_\_

**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

**PRESCRIPTION RENEWAL**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

