

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
	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	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**

- Neovascular (wet) age-related macular degeneration
- Visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO)
- Visual impairment due to macular edema secondary to branch retinal vein occlusion (BRVO)
- Visual impairment due to diabetic macular edema (DME)
- Choroidal neovascularization secondary to pathological myopia
- Other therapeutic indication(s) – Please specify: \_\_\_\_\_

**Information relating to neovascular (wet) age-related macular degeneration**

- Optimal visual acuity, after correction, between 6/12 and 6/96:  Yes  No
- Linear dimension of the lesion less than or equal to 12 disc areas:  Yes  No
- Presence of significant permanent structural damage to the centre of the macula:  Yes  No
- Has the disease progressed in the last three months?  Yes  No
- If so, please specify:  Confirmed by retinal angiography  Confirmed by optical coherence tomography  Confirmed by recent changes in visual acuity
- Treatment administered in conjunction with Verteporfin (Visudyne®):  Yes  No Which eye was treated?  Right eye  Left eye  Both eyes

**Information relating to visual impairment due to macular edema secondary to retinal vein occlusion (RVO) or to branch retinal vein occlusion (BRVO)**

- Optimal visual acuity, after correction:  Between 6/9 and 6/96  Between 6/12 and 6/120
- What is the thickness of the central retina? \_\_\_\_\_ Is there absence of afferent pupillary defect:  Yes  No

**Information relating to diabetic macular edema**

- Hemoglobin A1c: \_\_\_\_\_% Optimal visual acuity, after correction, between 6/9 and 6/96:  Yes  No
- What is the thickness of the central retina? \_\_\_\_\_ Is photocoagulation also indicated?  Yes  No

**Information relating to choroidal neovascularization secondary to pathological myopia**

- Axial length of the eyeball: \_\_\_\_\_ mm
- Myopia is greater than -6 diopters:  Yes  No
- Optimal visual acuity after correction is between 6/9 and 6/96:  Yes  No
- There is intraretinal or subretinal fluid or an active leak due to a choroidal neovascularization lesion:  Yes  No
- If so, please specify:  Observed by retinal angiography  Observed by optical coherence tomography

**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

**Prescription renewal**

Necessary information to assess response to treatment after three months or more. Please include the results of the following 2 exams:

**Left eye**

**Right eye**

Assessment of visual acuity measured with Snellen chart

Date: YYYY MM DD  Stabilization  Improvement  Degradation

Assessment of macular edema with an optical coherence tomography

Date: YYYY MM DD  Stabilization  Improvement  Degradation

Assessment of visual acuity measured with Snellen chart

Date: YYYY MM DD  Stabilization  Improvement  Degradation

Assessment of macular edema with an optical coherence tomography

Date: YYYY MM DD  Stabilization  Improvement  Degradation

