

## PRIOR AUTHORIZATION REQUEST

**Opzelura (ruxolitinib)**

PLEASE READ THE INSTRUCTIONS ON THE LAST PAGE.

### Section A. Patient identification (to be completed by the plan member)

Patient's last and first name		Relationship to plan member <input type="checkbox"/> Plan member <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child		Patient's date of birth YYYY MM DD	
Plan member's last and first name			Group No.		Certificate No.
No., street, apartment		City		Province	Postal code
Telephone Nos. - Home	Office	Extension	Email		

The response to this request includes confidential information. 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 private or provincial drug coverage, submit the request to that plan first. Then, send us the decision notice and this completed form.

**Private plan** – Is the patient covered by another private drug insurance plan?

☐ Yes – Provide a copy of the notice of approval or refusal. → ☐ Copy attached to this form.

Specify: Name of the insurer \_\_\_\_\_ Group No. \_\_\_\_\_ Certificate No. \_\_\_\_\_  
☐ No

**Provincial plan** – Has a request for reimbursement been submitted to your provincial plan?

☐ Yes – Provide a copy of the notice of approval or refusal. → ☐ Copy attached to this form.

☐ No – Explain: \_\_\_\_\_

**Patient support program** – Is the patient enrolled in a patient support program?

☐ Yes – Program name \_\_\_\_\_  
Contact person \_\_\_\_\_ Telephone No. \_\_\_\_\_ Extension \_\_\_\_\_  
☐ No

### Section B1. Declaration and authorization for the collection, use and communication of personal information

All the information I have provided on this form is accurate and complete. I acknowledge having read the Personal Information Management section on the last page. I authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, strictly for the purposes of managing my file and processing this request 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, 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. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to this request. A photocopy of this authorization is as valid as the original.

Signature of plan member \_\_\_\_\_ Date \_\_\_\_\_

Last name and first name of parent/legal guardian (if applicable) \_\_\_\_\_

Signature of patient or parent/legal guardian (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

## Section B2. Optional consent to communicate personal information to a third party

### Consent to communicate the decision on the prior authorization request

To ensure the request is processed efficiently, I authorize Desjardins Insurance to communicate the reasons for the decision to the healthcare professionals involved in the file and, if applicable, the drug manufacturer's patient support program.

☐ Yes

☐ No

My consent can be withdrawn at any time by contacting the program or Desjardins Insurance. I understand that my consent is optional and doesn't affect the processing of my request by Desjardins Insurance. My consent also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my request.

Signature of plan member \_\_\_\_\_ Date \_\_\_\_\_

Last name and first name of parent/legal guardian (if applicable) \_\_\_\_\_

Signature of patient or parent/legal guardian (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

### Section 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) \_\_\_\_\_

#### Disability

Is the patient currently on disability?

☐ Yes ☐ Total ☐ Partial For what reason? \_\_\_\_\_

☐ No

- To avoid processing delays, make sure all sections are completed: otherwise, the request will be returned to the plan member.
- For us to consider a diagnosis that is not listed below, provide supporting documents (clinical practice guidelines, clinical studies, etc.) that justify the drug's use in the given context.

#### Diagnosis

☐ Chronic atopic dermatitis

☐ Vitiligo

☐ Other therapeutic indications (please specify) \_\_\_\_\_

**Section C. Attending physician section (continued)****Information relating to chronic atopic dermatitis**

DLQI score \_\_\_\_\_

Affected BSA \_\_\_\_\_ %

Is phototherapy contraindicated or inaccessible? ☐ Yes ☐ No Explain \_\_\_\_\_EASI score \_\_\_\_\_ **OR** Severely affected area ☐ Face ☐ Palms ☐ Sole ☐ Genitals

Specify the severity of symptoms or limitations \_\_\_\_\_

**Information relating to vitiligo**

Specify the affected areas \_\_\_\_\_

Prior medication or treatment

Has the patient ever used medication or received treatment for this medical condition? ☐ Yes ☐ No

If not, explain \_\_\_\_\_

If so, list any medication used or any treatment received:

MEDICATION OR TREATMENT NAME	OUTCOME	TREATMENT PERIOD
Name: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From: YYYY MM DD
Dose: _____	Specify: _____	To: YYYY MM DD
Name: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From: YYYY MM DD
Dose: _____	Specify: _____	To: YYYY MM DD
Name: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From: YYYY MM DD
Dose: _____	Specify: _____	To: YYYY MM DD
Name: _____	<input type="checkbox"/> Ineffectiveness <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication	From: YYYY MM DD
Dose: _____	Specify: _____	To: YYYY MM DD

**Prescription renewal****Chronic atopic dermatitis**

EASI score while under treatment \_\_\_\_\_ DLQI score while under treatment \_\_\_\_\_

**Vitiligo**

Provide objective data showing a satisfactory clinical or biological response \_\_\_\_\_

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#### Section D. Instructions – How to complete and return this form

1. Complete sections A and B.
2. Ask your physician to complete section C. The plan 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

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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 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 Client Relations Centre at the number indicated on page 1 of this form.

#### Personal information management

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at [www.desjardins.com/privacy-policy](http://www.desjardins.com/privacy-policy) for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentation, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.