

PRIOR AUTHORIZATION REQUEST

Omlcylo (omalizumab)

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 ☐ Plan member ☐ Spouse ☐ 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

1. 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

2. Consent for the Desjardins Insurance Patient support program

THE PATIENT SUPPORT PROGRAM IS NOT APPLICABLE IN QUEBEC.

Designed to make it easier to manage your medical condition, the program has many benefits, including support from a team of pharmacists.

For complete details, see the following document: *Prior authorization drugs* pamphlet at www.desjardins.com/PAD.

For the sole purpose of the program, I authorize Desjardins Insurance to communicate to the mandated provider personal information about me that is needed for the program, including my medical information. I understand that the service provider may share information with the healthcare professionals involved in my file.

☐ 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 idiopathic urticaria

☐ Chronic rhinosinusitis with nasal polyps

☐ Moderate to severe persistent asthma

☐ Other therapeutic indications (please specify) _____

Section C. Attending physician section (continued)

Information relating to chronic idiopathic urticaria

Score according to the Urticaria Activity Score 7 (UAS7) _____

Information relating to chronic rhinosinusitis with nasal polyps

Indicate if the drug will be used ☐ As monotherapy ☐ In association with corticosteroids

Has the patient had any of the following symptoms in the past 12 months? **Check all observed symptoms:**

☐ Mucopurulent discharge ☐ Nasal obstruction and congestion ☐ Decreased sense or loss of smell ☐ Facial pressure or pain

Does the patient have documented bilateral nasal polyps? **Provide the relevant examination report:**

☐ Sinus computed tomography ☐ Direct endoscopic examination

Baseline IgE level _____ IU/mL

Information relating to moderate to severe persistent asthma

Skin test result ☐ Positive ☐ Negative

In vitro reactivity to a perennial aeroallergen ☐ Positive ☐ Negative

Baseline IgE level _____ IU/mL

Has the patient experienced clinically significant asthma exacerbations in the past 12 months? ☐ Yes, how many _____ ☐ No

Prior medication or treatment

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

If not, explain _____

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

MEDICATION OR TREATMENT NAME	OUTCOME	TREATMENT PERIOD
Name: _____ Dose: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD
Name: _____ Dose: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD
Name: _____ Dose: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD
Name: _____ Dose: _____	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD

Prescription renewal

Moderate to severe persistent asthma

Provide objective evidence of drug effectiveness _____

Chronic rhinosinusitis with nasal polyps

Following treatment, have you observed:

A reduction in mucosal inflammation and edema? ☐ Yes ☐ No

A reduction of exacerbations? ☐ Yes ☐ No

Chronic idiopathic urticaria (see next page)

Chronic idiopathic urticaria

	UAS7 score	Date (YYYY-MM-DD)
Starting value		
Treatment in progress		
Most recent value		

	UAS7 score	Date (YYYY-MM-DD)
Starting value		
Most recent value		

Current UAS7 score indicating a relapse _____ Assessment date _____

- Complete sections A and B.
- 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.
- 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.
- Choose one of the following options to send us this form or any other required documents.

1. Go to desjardins.com/planmember and click on **Log in to your account**.
2. Enter your user ID and password to log in to your group insurance file.
3. In the **Tools and resources** tab, select *Send documents*, then click on **Start**.
4. In the **Type of insurance** drop-down menu, select *Health insurance*.
5. In the **Type of document** drop-down menu, select *Forms*.
6. In the list under **Document Name**, select *Prior Authorization Request – Drugs*.
7. Attach your documents and complete your submission.

Desjardins Insurance, Group Insurance - Health Claims, C. P. 3950, Lévis (Québec) G6V 8C6

Desjardins Insurance, Group Insurance - Health Claims, 418-838-2134 or 1-877-838-2134 (toll-free)

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.

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