

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

PRIOR AUTHORIZATION REQUEST

KUVAN (SAPROPTERIN DIHYDROCHLORIDE)

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM.

	PATIENT IDENTIFICATION	ON - To be completed by the me	mher						
	Patient's last and first name	ATIENT IDENTIFICATION – To be completed by the member.			Relationship with member			Patient's date of birth	
				Membe	•	Dependent chil	YYYY	MM DD	
	Member's last and first nan	ne		IVICITIBE	Contract No.	·	Certificate No.		
	No., street, apt.		City				Province	Postal code	
	Telephone Nos – Home:	Office	:	Exte	nsion:	Email:			
		equest includes confidential infor		•					
	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.								
		Does the patient have drug co	verage under a private	incurance nla	n?				
	PRIVATE PLAN	☐ Yes – Please provide a copy		•		attached to this for	m.		
		Specify: Name of the insurer:	• • •						
		No			Contract No	···	_ Certificate No	.:	
		Has a request for reimbursement been submitted under your provincial plan?							
	PROVINCIAL PLAN	Yes – Please provide a copy			. —	attached to this for	m.		
		No – Please explain:	or the hotice of appre	7141 01 10145411	,	, 4444	•••		
		<u> </u>	ient support program?	Yes	No				
	PATIENT SUPPORT	Is the patient enrolled in a patient support program?							
	PROGRAM	Contact person:			Telepho	ne No :	-	Extension:	
1	DECLARATION AND AL	ITHORIZATION FOR THE CO	LECTION AND COL	MMUNICAT	· · · · · ·			EXCENSION.	
	the information deemed ne and insurance companies; (when necessary use the per	urance, 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 information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, d 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) en 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 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:	re of member: Date:							
	Last name and first name of	ast name and first name of parent/legal guardian (if applicable):							
		ent/legal guardian (if applicable)				Date:			
2		IMUNICATION OF PERSONA		O A THIRD	PARTY	Dute.			
_	To help us process your cla	nelp us process your claim more efficiently, do you authorize Desjardins Insurance to inform the patient support program and the attending physician or the attending sician's medical team of the reasons for the decision on your prior authorization request?							
	Yes No								
	Signature of member:	re of member: Date:							
	ast name and first name of parent/legal guardian (if applicable):								
	Signature of patient or par	ent/legal guardian (if applicable)	e): Date:						
	ATTENDING PHYSICIAL	N SECTION – To be completed b	y the attending physic	ian.					
	Physician's last and first name (PLEASE PRINT)		Lic	ense No.	Specialty				
	No., street, suite City		<u> </u>		<u> </u>	Province	Postal code		
Telephone No.: Fax No.:									
	Signature of physician:					Date:			
	Drug name		Formulation	Strength	Dosage	Patient's weight	Scheduled dur	ation of treatment	
	Where is the drug administ	nere is the drug administered?							
		Other (please spe							
1	0158E (2021-08*)	Desjardins Insuranc	e refers to Desiardin	ns Financial S	ecurity Life Assu	urance Company.		Page 1 of 2	

ATTENDING PHYSICIAN SECTION – Continued

DIAGNOSIS

- . 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.

J Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive PKU ☐ Patient with hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive Phenylketonuria								
☐ Patient with hyperphenylalaninemia (HPA) due to tet ☐ Other therapeutic indication(s) – Please specify:	ranydrobiopterin (BH4)-responsive Phenyiketonuria							
— Other therapeutic indication(s) — riease specify:								
INFORMATION RELATING TO DIAGNOSIS								
s the drug administered in conjunction with a Phenylalanine restricted diet?								
PRIOR MEDICATION OR TREATMENT Has the patient ever used medication or received treatn	nent for this medical condition?							
If not, please explain:								
If so, please list any medication already used or any trea	tment already received for this medical condition:							
MEDICATION OR TREATMENT NAME	оитсоме	TREATMENT PERIOD						
Name:	Inefficiency Intolerance Contraindication	From:						
Dose:	Specify:	To:						
Name:	Inefficiency Intolerance Contraindication	From:						
Dose:	Specify:	To:						
Name:	Inefficiency Intolerance Contraindication	From:						
Dose:	Specify:	To:						
Name:	Inefficiency Intolerance Contraindication	From:						
Dose:	Specify:	To:						
PRESCRIPTION RENEWAL								
Please provide objective data that shows a satisfactory of	clinical or biological response:							
Serum phenylalanine concentration before treatment: _	μmol/L							
Actual serum phenylalanine concentration:	μmol/L							
INSTRUCTIONS – HOW TO COMPLETE AND RE	TURN THIS FORM							
1. Complete sections A and B.								
2 Ask your physician to complete section C. The member	er is responsible for assuming any costs incurred to complete this form or to o	btain additional information.						

D

- 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.