

# Information and consent for the patient support program for specialty drugs

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.

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 no	ecessary)		
Signature of the parent or legal guardian (if necessary)		Date	

This consent is an integral part of the attached Prior Authorization Request form.



C. P. 3950 Lévis (Québec) G6V 8C6 desjardinslifeinsurance.com/planmember 1-844-410-6485

# PRIOR AUTHORIZATION REQUEST

**NUCALA (MEPOLIZUMAB)** 

## PLEASE READ THE INSTRUCTIONS ON THE LAST PAGE OF THIS FORM.

	PATIENT IDENTIFICAT	ION – To be completed by the member.					
	atient's last and first name		Relationship with member			Patient's date of birth	
			☐ Member	$\square$ Spouse	Dependent child	i YYYY	MM DD
	Member's last and first na	me		Contract No.		Certificate No.	
	No., street, apt.	o., street, apt. City				Province	Postal code
	Telephone Nos – Home:	Office:	Extensi	on:	Email:		
		request includes confidential information, please indicate	•		ned of the decision:		
	☐ By mail (The response	to your request will be sent to the address indicated in thi	s section.)	☐ By fax:			
		s: If the patient has coverage under a private insurance p a copy of the decision notice and this form filled out by t				n, please subm	nit the request to this
		Does the patient have drug coverage under a private	insurance plan?				
		☐ <b>Yes</b> – Please provide a copy of the notice of approv	· ·	→ □Сору	attached to this form	n.	
	PRIVATE PLAN	Specify: Name of the insurer:		Contract No.	:	_ Certificate No	.:
		□No					
		Has a request for reimbursement been submitted und	der your provinc	ial plan?			
	PROVINCIAL PLAN	Yes – Please provide a copy of the notice of approv	val or refusal.	→ □Сору	attached to this form	n.	
		□ <b>No</b> – Please explain:					
	DATIENT CURRORT	Is the patient enrolled in a patient support program?	Yes N	o			
	PATIENT SUPPORT PROGRAM	If so – Program name:					
		Contact person:		Telephon	e No.:	E	Extension:
L	<b>DECLARATION AND A</b>	UTHORIZATION FOR THE COLLECTION AND CON	MUNICATIO	N OF PERSON	NAL INFORMATIO	N	
	Insurance, strictly for the p the information deemed n and insurance companies; when necessary use the pe	e provided on the claim form is accurate and complete. purposes of managing my file and settling this claim to: (a ecessary to manage my file. The non-exhaustive list of sou (b) communicate to the said persons or organizations only ersonal information it may have about me in existing files the oncerning my dependents, insofar as applicable to the claim	) collect from ar rces from which the personal inf nat are now clos	y person or legal information ma formation about ed. This authoria	al entity, or from any by be collected includ me that is deemed n zation is also valid for	public or parap es healthcare pr ecessary for the the collection, u	ublic organization, only rofessionals or facilities, purposes of my file; (c)
	Signature of member:	gnature of member: Date:					
	Last name and first name	of parent/legal guardian (if applicable):					
	Signature of patient or pa	rent/legal guardian (if applicable):			Date:		
2		MMUNICATION OF PERSONAL INFORMATION TO					
		laim more efficiently, do you authorize Desjardins Insura of the reasons for the decision on your prior authorization		he patient supp	port program and the	e attending phy	sician or the attending
	Yes No						
	Signature of member:				Date:		
	Last name and first name	of parent/legal guardian (if applicable):					
	Signature of patient or pa	rent/legal guardian (if applicable):			Date:		

### **CONTINUED ON THE BACK**

С	ATTENDING PHYSICIAN SECTION – To be completed by	y the attending physi	cian.							
	Physician's last and first name (PLEASE PRINT)		L	icense No.	Specialty					
	No., street, suite	City				Province	Postal code			
	Telephone No.:		Fax No.:							
•	Signature of physician:  Drug name	Scheduled dur	luration of treatment							
		sician's office	Private clinic	Hospital – In	patient Ho	spital – Outpatier	nt			
	☐ Other (please specify):  IMPORTANT – The physician must have previously verified the inhalation technique, adherence to pharmacological treatment and the implementation of strategies to reduce exposure to pneumallergens to which the person obtained a positive result during skin test or in vitro reactivity test.									
		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								
	DIAGNOSIS									
	Severe eosinophilic asthma	Sovere ensinesh	ilic asthma in	patients receiving ora	al corticostoroids	for more than 2 m	onths			
	Hypereosinophilic Syndrome	Chronic Rhinosir			ai coi ticosteroius	or more than 5 h	iontris			
	Other therapeutic indication(s) – Please specify:	CHIOTHE KIHIOSH	iusitis With Na	sai poiyps						
INFORMATION RELATING TO SEVERE EOSINOPHILIC ASTHMA										
	Has the patient experienced asthma exacerbations requiring	atient experienced asthma exacerbations requiring the use of systemic corticosteroid in the past 12 months?   Yes  No How many:								
If the patient is already under continuous systemic corticosteroid therapy, has he experienced any exacerbations requiring a dose increase										
	in the last 12 months?  Yes No How many:									
Blood eosinophil at initiation of treatment: cells/μL  Blood eosinophil in past twelve months: cells/μL  Please provide results for at least one of the following questionnaires:  Asthma Control Questionnaire (ACQ): St George's Respiratory Questionnaire (SGRQ):										
	Asthma Control Test (ACT): Asthma Quality of Life Questionnaire (AQLQ):									
		FORMATION RELATING TO SEVERE EOSINOPHILIC ASTHMA IN PATIENTS RECEIVING ORAL CORTICOSTEROIDS FOR MORE THAN 3 MONTHS								
	Date of initiation of oral corticosteroid therapy:									
	Blood eosinophil at initiation of treatment:		oage							
	blood eosilophii at ilittation of treatment.	ceiis/ με								
	INFORMATION RELATING TO HYPEREOSINOPHILIC SYND	ROME								
	Please indicate since when patient has started symptoms of $\boldsymbol{\boldsymbol{h}}$	nypereosinophilic syr	idrome:							
	Please indicate if there is an identifiable non-hematologic sec	condary cause: $\Box$	Yes 🗌 No	If yes, please do	cument:					
	Blood eosinophil at initiation of treatment:		_x10° cells/L							
	INFORMATION RELATING TO CHRONIC RHINOSINUSITIS	WITH NASAL POLY	PS							
	Has the patient had any or more of the following symptoms in			ne symptoms observe	ed)					
	Mucopurulent discharge		, , , , , , ,	, ,	,					
	Nasal obstruction and/or congestion									
	Decreased or absent sense of smell									
	Facial pressure or pain									
	The patient has bilateral nasal polyps, documented by – plea:	se provide the applic	ahle evamina	tion report:						
		se provide the applic	avic examilla	поптерога						
	Did the patient undergo endoscopic sinus surgery?		No place em	olain :						
	Dia the patient undergo endoscopic silius surgery:	163	vo, picase ex	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						

#### PRIOR MEDICATION OR TREATMENT Has the patient ever used medication or received treatment for this medical condition? $\Box$ Yes $\Box$ 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 TREATMENT PERIOD OUTCOME MM DD From: Inefficiency Intolerance Contraindication Name: Dose: Specify: To: MM DD From: Name: Inefficiency Intolerance Contraindication MM DD Specify: Dose: To: MM DD From: Name: Intolerance Contraindication Inefficiency Specify: Dose: To: MM DD Name: Inefficiency Intolerance Contraindication From: MM DD Dose: Specify: To: PRESCRIPTION RENEWAL Severe eosinophilic asthma - Please provide results for at least one of the following questionnaires: Asthma Control Questionnaire (ACQ): \_\_\_ St George's Respiratory Questionnaire (SGRQ): \_\_\_ Asthma Control Test (ACT): \_\_\_ Asthma Quality of Life Questionnaire (AQLQ): \_\_\_\_\_ Number of exacerbations annually under treatment: — Severe eosinophilic asthma in patients receiving oral corticosteroids for more than 3 months Corticosteroid used: \_ Dosage: \_ Hypereosinophilic Syndrome x109 cells/L Blood eosinophil in past twelve months: \_ Chronic rhinosinusitis with nasal polyps Following treatment with Nucala, have you observed: ☐ Yes ☐ No reduction in mucosal inflammation and edema? reduction of acute exacerbations? INSTRUCTIONS - HOW TO COMPLETE AND RETURN THIS FORM 1. Complete sections A and B. 2. Ask your physician to complete section C. The 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

ATTENDING PHYSICIAN SECTION - (continued)

by mail: Desjardins Insurance

Group Insurance, Health Claims,

Group Insurance, Health Claims

418-838-2134 or 1-877-838-2134 (toll-free)

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.