

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.

PRIVATE PLAN

Does the patient have drug coverage under a private insurance plan?
 Yes – Please provide a copy of the notice of approval or refusal. → **Copy attached to this form.**
 Specify: Name of the insurer: _____ Contract No.: _____ Certificate No.: _____
 No

PROVINCIAL PLAN

Has a request for reimbursement been submitted under your provincial plan?
 Yes – Please provide a copy of the notice of approval or refusal. → **Copy attached to this form.**
 No – Please explain: _____

PATIENT SUPPORT PROGRAM

Is the patient enrolled in a patient support program? **Yes** **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	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): _____

- 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

Severe primary insulin-like growth factor-1 deficiency (SPIGFD)

Other therapeutic indication(s) – Please specify: _____

INFORMATION RELATING TO SEVERE PRIMARY INSULIN LIKE GROWTH FACTOR-1 DEFICIENCY (SPIGFD)

The diagnosis is confirmed by a genetic test: Yes No

Does the most recent radiography shows epiphyseal closure: Yes No

Will the treatment be administered in association: Yes No If yes, please explain : _____

Please precise score Z: _____

Please precise the percentil corresponding to basal IGF-1 level for age and gender: _____

Please indicate if one or more of the following secondary form of IGF-1 deficiencies apply :

- Malnutrition
- Hypopituitarism
- Hypothyroidism
- Chronic treatment with pharmacologic dose of anti-inflammatory steroids
- Other, please specify : _____

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

C ATTENDING PHYSICIAN SECTION – To be completed by the attending physician (following).

PRESCRIPTION RENEWAL

Please indicate height velocity in the past 12 months: _____ cm.

Please indicate bone age of the patient: _____

Does the most recent radiography shows epiphyseal closure : Yes No

Will the treatment be administered in association: Yes No If yes, please specify: _____

Please provide objective data that shows a satisfactory clinical or biological response: _____

D 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 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.