

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? <input type="checkbox"/> Yes – Please provide a copy of the notice of approval or refusal. → <input type="checkbox"/> Copy attached to this form. Specify: Name of the insurer: _____ Contract No.: _____ Certificate No.: _____ <input type="checkbox"/> No
PROVINCIAL PLAN	Has a request for reimbursement been submitted under your provincial plan? <input type="checkbox"/> Yes – Please provide a copy of the notice of approval or refusal. → <input type="checkbox"/> Copy attached to this form. <input type="checkbox"/> No – Please explain: _____
PATIENT SUPPORT PROGRAM	Is the patient enrolled in a patient support program? <input type="checkbox"/> Yes <input type="checkbox"/> 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:** _____

CONTINUED ON THE BACK

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

- Unresectable or metastatic melanoma with BRAF V600 mutation
- Adjuvant treatment of a melanoma with BRAF V600 mutation
- Other therapeutic indication(s) – Please specify: _____

INFORMATION RELATING TO UNRESECTABLE OR METASTATIC MELANOMA

Has the BRAF V600 mutation been identified with a validated test? Yes No

What is the ECOG performance status? _____

Will the treatment be a combination of Tafinlar and Mekinist? Yes No

Does the patient show brain metastases? Yes No

If yes, are the metastases stable? Yes No

(Note: Is meant by stable that there is no growth or new lesions suggesting progression)

INFORMATION RELATING TO THE ADJUVANT TREATMENT OF A MELANOMA WITH BRAF V600 MUTATION

Does the patient show:

Involvement of regional lymph nodes? Yes No

In-transit or satellite metastases without ganglionic involvement? Yes No

Has the melanoma been completely resected? Yes No

Please specify the date of the last complete resection: _____

ECOG performance status: _____

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

