





**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.**

<b>PRIVATE PLAN</b>	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
<b>PROVINCIAL PLAN</b>	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: _____
<b>PATIENT SUPPORT PROGRAM</b>	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 – (continued)****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: _____ Dose: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD
Name: _____ Dose: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD
Name: _____ Dose: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD
Name: _____ Dose: _____	<input type="checkbox"/> Inefficiency <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication Specify: _____	From: _____ YYYY MM DD To: _____ YYYY MM DD

**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**Blood eosinophil in past twelve months: \_\_\_\_\_ x10<sup>9</sup> cells/L**Chronic rhinosinusitis with nasal polyps**

Following treatment with Nucala, have you observed :

reduction in mucosal inflammation and edema?  Yes  Noreduction of acute exacerbations?  Yes  No**D INSTRUCTIONS – HOW TO COMPLETE AND RETURN THIS FORM**

- Complete sections A and B.
- 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.
- 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.
- 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.