

C. P. 3950 Lévis (Québec) G6V 8C6 desjardinslifeinsurance.com/planmember Tel.: 1-844-410-6485 Fax: 1-877-838-2134 418-838-2134

## PRIOR AUTHORIZATION REQUEST

KALYDECO (IVACAFTOR) ORKAMBI (LUMACAFTOR / IVACAFTOR) SYMDEKO (TEZACAFTOR / IVACAFTOR AND IVACAFTOR) TRIKAFTA (ELEXACAFTOR / TEZACAFTOR / IVACAFTOR AND IVACAFTOR)

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

Α	PATIENT IDENTIFICATION – To be completed by the member.								
	Patient's last and first name			Relationship with member			Patient's date of birth		
				Spouse	Dependent child	d YYYY	MM DD		
	Member's last and first name			Contract No.		Certificate No.			
	No., street, apt. City					Province	Postal code		
	Telephone Nos – Home: Office:			on:	Email:				
	Since the response to this r	equest includes confidential information, please indicate	how you would	like to be inform	ned of the decision:				
	By mail (The response to your request will be sent to the address indicated in this section.)								
	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 coverage under a private i							
	PRIVATE PLAN	Yes – Please provide a copy of the notice of approv Specify: Name of the insurer:			attached to this form		:		
		Has a request for reimbursement been submitted und		·					
	PROVINCIAL PLAN	Yes – Please provide a copy of the notice of approv No – Please explain:	val or refusal.	→Сору	attached to this form	m.			
	PATIENT SUPPORT	Is the patient enrolled in a patient support program?	Yes N	0					
	PROGRAM	If so – Program name:			•				
D1		Contact person:					xtension:		
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, hereina					hereinafter Desiarding				
	Insurance, strictly for the purposes of managemy 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		IMUNICATION OF PERSONAL INFORMATION TO							
		aim more efficiently, do you authorize Desjardins Insura f the reasons for the decision on your prior authorization		he patient supp	oort program and th	e attending phy	sician or the attending		
	Yes								
>	Signature of member:				_ Date:				
	Last name and first name of parent/legal guardian (if applicable):								
	Signature of patient or par	ent/legal guardian (if applicable):			Date:				

## CONTINUED ON THE BACK

use in the given context.     DIAGNOSIS     Cystic fibrosis   Other therapeutic indication(s) – Please specify:     INFORMATION RELATING TO CYSTIC FIBROSIS   Does the patient have a CFTR gene mutation?   No   Yes – please describe:   Does the patient have the F508del mutation in the CFTR gene?   No   Yes – the patient is:   Homozygous   Heterozygous   Please specify if patient has undergone lung transplant?	C ATTENDING PHYSICIAN SECTION – To be completed by the attending physician.							
Image:       Date:         Signature of physician:       Dote:         Drug name       Formulation       Strength       Dosage         Charles of the strength       Dosage       Scheduled duration of treatment         Charles of the strength       Dosage       Scheduled duration of treatment         Charles of the strength       Dosage       Scheduled duration of treatment         Charles of the strength       Descing       Descing         Make sure to fill out all sections so are can process the request faster. If any information is missing, we will send the form back to the member.       Descing         Descing of the strength       Descing of the strength       Descing of the strength         Descing of the strength       Descing of the strength       Descing of the strength         Does the patient have a CFIR gene mutation?       No       Yes - the patient is:       Homocrygous       Heteroprygous         Please specify if patient have undergone lung transplant?       No       'Yes - the patient is:       Homocrygous       Heteroprygous         Descing of the strength of the strength       Sacking measure       Follow-up date       Follow-up date       Follow-up date         Manderory assessment       Trease specify if assessment if the strength of strength       Income of strength       Income of strength       Income of strength <td>Physician's last and first name (PLEASE P</td> <td colspan="2"></td> <td>nse No.</td> <td>Specialty</td> <td></td> <td colspan="2"></td>	Physician's last and first name (PLEASE P			nse No.	Specialty			
Signature of physician:       Date:         Drug name       Formulation       Strength       Dosage       Scheduled duration of treatment         Where is the drug administered?       Intom       Physician's office       Private clinic       Intospital - Impatient       Hospital - Outpatient         • 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.       • Intoget to consider any diagons so the mentioned on this form, we need supporting documents (clinical practice guidelines, clinical studies, etc.) that justify the drue in the given context.         DIAGNOSIS       • Output threageuitic indication(s) – Please specify:       • Nordent to TER gene mutation?       No       Yes - the patient is:       Homoprygous       Intercorrygous         Please specify if patient has undergone lung transplant?       No       Yes - the patient is:       Homoprygous       Intercorrygous         Please specify if patient has undergone lung transplant?       No       Yes       Yes - the patient is:       Follow-up date	No., street, suite	City		1	Province	Postal code		
Drug name       Formulation       Strength       Dosage       Scheduled duration of treatment         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 to 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 diagonolis on tennitoned on this form, we need supporting documents (clinical practice guidelines, clinical studies, etc.) that justify the drug set in the given context.         DIAGNOSIS       Import therapeutic indication(s) – Please specify:       INFORMATION RELATING TO CYSTIC FIBROSIS         Does the patient have the F508del mutation in the CFIR gene?       No       Ives - the patient is:       Homozygous       Heterozygous         Please specify if patient has undergone lung transplant?       No       Ives       Ives - the patient is:       Follow-up measure       Follow-up date       Follow-up measure       Follow-up date       Follow-up date	Fax No.:							
Where is the drug administered? <ul> <li>Phone</li> <li>Physicate clinic</li> <li>Hone drug administered?</li> <li>Other (please specify):</li> <li>Make sure to fill out all seconds not composed faster. If any information is missing, we will send the form back to the member.</li> <li>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 use in the given context.</li> <li>DIAGNOSIS</li> <li>Other therapeutic indication(s) – Please specify:</li> <li>INFORMATION RELATING TO CYSIC (PLBAS)S</li> <li>Does the patient have a CFIR gene mutation?</li> <li>No</li> <li>Ves – please describe:</li> <li>Does the patient have the FS06del mutation in the CFIR gene?</li> <li>No</li> <li>Ves – the patient is:</li> <li>Homorygous</li> <li>Heterozygous</li> <li>Please specify if patient has undergone long transplant?</li> <li>No</li> <li>Ves</li> <li>Mandatory assessment</li> <li>Pascline date</li> <li>Pascline date</li> <li>Pascline date</li> <li>Pollow-up measure</li> <li>Follow-up measure</li></ul>	Signature of physician:					Date:		
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 drives in the given context.   DIAGNOSIS   Opsite fibrosis   Other therapeutic indication(s) – Please specify:   NOOMATION RELATING TO CYSTIC FIBROSIS   Does the patient have a GFIR gene mutation?   No   Oes the patient have the F508del mutation in the CFIR gene?   No   Ves   Mandatory assessment   Baseline date   Anderory assessment   Baseline date   Percent predicted FEV   At least two of the three following:   No   Number of exacerbations and   Integrate the date we distributed in the CFIR gene?   Number of inducer to guide (BMI)   Percent predicted FEV   At least two of the three following:   No   No maker of the patient have used medication or received treatment for this medical condition:   Priot please specify:   To:   Where of the set bollowing:   No the patient the patient down as index (BMI)   No the patient down asses the CFIR on the medical condition:   The patient set weight data and the any difference of the medical condition:   No patient set weight   No patient set weight   No patient set weight   The patient sequide indication and medical condition:   No p	Drug name		Formulation	Strength	Dosage		Scheduled dura	ation of treatment
• In order to consider any diagnosis not mentioned on this form, we need supporting documents (clinical practice guidelines, clinical studies, etc.) that justify the draws in the given context.   DIAGNOSIS	Where is the drug administered?	_						
Cystic fibrosis         Other therapeutic indication(s) - Please specify:         INFORMATION RELATING TO CYSTIC FIBROSIS         Does the patient have de CFIR gene mutation?       No       'Yes - please describe:         Does the patient have the F508del mutation in the CFIR gene?       No       'Yes - the patient is:       'Homozygous       Heterozygous         Please specify:       Baseline date       Baseline measure       Follow-up date	<ul> <li>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.</li> <li>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</li> </ul>							that justify the drug's
□ Other therapeutic indication(s) – Please specify:         INFORMATION RELATING TO CYSTIC FIBROSIS         Does the patient have a CFTR gene mutation?       \no       \res - please describe:         Does the patient have a CFTR gene mutation?       \no       \res - please describe:         Does the patient have the F508del mutation in the CFTR gene?       \no       \res - the patient is:       \Homozygous       \Heterozygous         Please specify if patient has undergone lung transplant?       \no       \res       Follow-up date       Fol	DIAGNOSIS							
Does the patient have a CFTR gene mutation?       No       Yesplease describe:       Heterozygous       Heterozygous         Does the patient have the F508del mutation in the CFTR gene?       No       Yes the patient is:       Homozygous       Heterozygous         Please specify if patient has undergone lung transplant?       No       Yes       Yes       Follow-up date       Follow-up measure       Follow-up date       Follow-up measure       Follow-up date       Follow-up measure       Follow-up		ase specify:						
Does the patient have the FS08del mutation in the CFTR gene?       No       Yes - the patient is:       Homozygous       Heterozygous         Please specify if patient has undergone lung transplant?       No       Yes       Follow-up date       Follow-up measure       Follow-up date		_						
Please specify if patient has undergone lung transplant?       No       Yes         Mandatory assessment (2 times per year)       Baseline date YYYY MML DD       Baseline measure       Follow-up date YYYY MML DD       Follow-up date YYY MML DD       Follow-up d							7/////	
Mandatory assessment (2 times per year)       Baseline date VYYY MML DD       Baseline measure       Follow-up date VYYY MML DD       Follow-up date VYY MML DD       Follow-up d						zygous		
Percent-predicted FEV       Image: Contraindication of the three following:       Image: Contraindication of the three following:         1. Number of exacerbations and hospitalizations requiring antibiotics in the past 6 months       Image: Contraindication of the CFQ-R or Quality of life according to EQ-5D-3L       Image: Contraindication of the CFQ-R or Quality of life according to EQ-5D-3L         3. Patient's weight       Image: Contraindication of the CFQ-R or Quality of life according to EQ-5D-3L       Image: Contraindication of the CFQ-R or Quality of life according to EQ-5D-3L         3. Patient Sweight       Image: Contraindication of the CFQ-R or Quality of life according to EQ-5D-3L       Image: Contraindication of the CFQ-R or Quality of life according to EQ-5D-3L         3. Patient body mass index (BMI)       Image: Contraindication of the CFQ-R or Quality of this medical condition?       Image: Contraindication of the CFQ-R or Quality of the CFQ-R or Quality of the CFQ-R or Quality of the Contraindication of the CFQ-R or Quality of the CFQ-R or Q	Mandatory assessment	Baseline date		Follow-up	date Follow-up m	easure F		Follow-up measure
1. Number of exacerbations and hospitalizations requiring antibiotics in the past 6 months       Image: Contraindication       Image: Contraindication <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
hospitalizations requiring antibiotics in the past 6 months       Image: Specify:       Image: Specify: Specify:       Image: Specify: Speci	At least two of the three following:							
or Quality of life according to EQ-5D-3L	hospitalizations requiring antibiotics							
4. Patient body mass index (BMI)								
MEDICATION OR TREATMENT         Has the patient ever used medication or received treatment for this medical condition?       Yes       No         If not, please explain:	3. Patient's weight							
Has the patient ever used medication or received treatment for this medical condition?       Yes       No         If not, please explain:	4. Patient body mass index (BMI)							
Name:       Inefficiency       Intolerance       Contraindication       From:       YYYY       MM       DD         Dose:       Specify:       To:       To:       YYYY       MM       DD         Name:       Inefficiency       Intolerance       Contraindication       From:       YYYY       MM       DD         Name:       Inefficiency       Intolerance       Contraindication       From:       YYYY       MM       DD         Name:       Inefficiency       Intolerance       Contraindication       From:       YYYY       MM       DD	Has the patient ever used medication or If not, please explain:							
Name:       Inefficiency       Intolerance       Contraindication       From:         Dose:       Specify:       To:       YYYY       MM_DD         Name:       Inefficiency       Intolerance       Contraindication       From:       YYYY       MM_DD         Name:       Inefficiency       Intolerance       Contraindication       From:       YYYY       MM_DD         Name:       Inefficiency       Intolerance       Contraindication       From:       YYYY       MM_DD	MEDICATION OR TREATMENT NAME		OUTCOME					
Dose:     Specify:     To:       Name:     Inefficiency     Intolerance     Contraindication       From:     YYYY     MM     DD	Name:		Inefficiency Intolerance Contraindic			ation	From:	
Name:     Inefficiency     Intolerance     Contraindication     From:	Dose:		Specify:				To:	
	Name:		Inefficiency Intolerance Contraindicat				From:	
	Dose: Name:		Specify:				To:	
Name:     Inefficiency     Intolerance     Contraindication     YYYY     MM     DD			Inefficiency Intolerance Contraindication			From:		
Dose: Specify: To:	Dose:		Specify:				To:	
Name: Inefficiency Intolerance Contraindication	Name:		Inefficiency Intolerance Contraindicati			cation	From:	
Dose: Specify: To:	Dose:		Specify:					TTTT IVIIVI DD

PRESCRIPTION RENEWAL

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