La Capitale

Request for Assessment
of a Prior Authorization Drug

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, PO Box 1500 Quebec QC G1K 8X9
Or by fax at 418 646-0888 or 1 877 210-9766

Need help completing this form?
Call us at 418 644-4200 or 1 800 463-4856.
You can download a printable version of this form from La Capitale's website at
lacapitale.com/forms

1. IDENTIFICATION OF PARTICIPANT

As indicated on your insurance certificate

Group No.	Identification No.

Last name	First name

2. IDENTIFICATION OF PHYSICIAN (to be completed by the attending physician)

Last name	First name

Licence No.	Specialty	Fax

3. IDENTIFICATION OF PATIENT

Last name	First name	Gender ☐ M ☐ F	Weight ______ ☐ kg ☐ lb.

No.-street, apt.	City	Province	Postal code

Home tel.	Work tel.	Ext.	Date of birth (Year / Month / Day)	Relationship to the participant ☐ Participant ☐ Spouse ☐ Dependent

Provincial plan

Has a request for reimbursement been submitted under your provincial plan?

☐ **Yes** – Please attach a copy of the decision letter – ☐ Copy attached

☐ **No** – Please explain: ____________________

Patient support program

Is the patient enrolled in a patient support program? ☐ Yes ☐ No

If so, – Name of program: ____________________

Contact person's name: ____________________

Telephone: ____________________

4. DRUG IDENTIFICATION – It is important to use a separate form for each drug

The medication will be administered:	Type of request
☐ At home, at a CLSC or at a private office	☐ Initial request – Complete sections **5**, **7** and **8**
☐ At a hospital, residential and long-term care centre, public or subsidized private nursing home, including outpatient consultations	☐ Treatment change request – Complete sections **5**, **7** and **8**
☐ Other location, specify: ____________________	☐ Treatment renewal request – Complete sections **6**, **7** and **8**

Name of drug	Pharmaceutical form	Strength	Dosage	Expected duration of treatment **From** (YYYY/MM/DD)	**To** (YYYY/MM/DD)

5. REASONS – Initial request or treatment change

Diagnosis and therapeutic indication: ____________________

Targeted therapeutic objective: ____________________

Date of onset of symptoms, complications or manifestations of the condition: Year / Month / Day

P1016E (11-2017)

5. REASONS (Cont.)

Please specify the functional limitations associated with the diagnosis before this treatment was started: ______

In the absence of physical functional impairment, is it likely that the progression of the condition or its complications may impact the person's morbidity or mortality? ______

Specify the gravity of the condition requiring treatment. If there is a scale for evaluating the gravity, please provide it. In the case of a symptom, please describe the intensity, frequency and duration: ______

Attach any clinical test results relevant to this request.

SUMMARY OF PREVIOUS MEDICATION OR TREATMENT ADMINISTERED FOR THIS CONDITION

Medication/treatment	Dosage	Treatment period		Results of the treatment including effectiveness and the reason medication was stopped
		From (YYYY/MM/DD)	**To** (YYYY/MM/DD)	

MEDICATION OR TREATMENT KNOWN TO BE EFFECTIVE FOR THIS CONDITION, WHICH CANNOT BE PRESCRIBED

Medication/treatment	Reasons or circumstances that prevent use

If treatment with the requested medication has started, specify the start date and therapeutic benefits: Year Month Day

6. CLINICAL INFORMATION – Treatment renewal

Specify the therapeutic benefits justifying extension of treatment (include results, e.g. HAQ, PASI, etc.): ______

7. OTHER INFORMATION

______

8. ATTENDING PHYSICIAN'S STATEMENT

I certify that all information provided on this form is accurate.

X ______ Date: Year Month Day

Signature of attending physician

9. PATIENT'S STATEMENT AND AUTHORIZATION

I authorize any healthcare professional or public or private healthcare institution, pharmacist, provincial prescription drug insurance plan, insurer, employer, rehabilitation company or other person or establishment holding medical or financial information concerning me to provide La Capitale with any information that it may consider necessary for the examination of my request. I authorize La Capitale to carry out all investigations required to verify the validity of my request. I understand that La Capitale or its representatives may use the information provided on this form and at the time of previous requests under this plan (if relevant) for the management of my file and the production of statistical reports. I declare that the information provided on this form is true and complete. A photocopy of this authorization is considered as valid as the original.

X ______ Date: Year Month Day

Signature of the insured

P1016E (11-2017)