iA Financial Group

REQUEST FOR REFERENCE BIOLOGIC DRUG EXCEPTION

GROUP INSURANCE

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5
Fax: 1-855-884-9811

All Other Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3
Fax: 1-877-780-7247

1. IMPORTANT – PLEASE READ CAREFULLY

Your request for the biologic reference drug exception will be reviewed and you will be informed, whether or not it has been approved.

You should not submit your claim before you receive your approval.

All medical information received from you and your physician will be kept confidential.

2. MEMBER/PATIENT INFORMATION

Member's first name _____ Last name _____

Policy no. _____ Certificate no. _____

Address _____ Postal code _____

Telephone _____ Email _____

Patient's first name (if different) _____ Last name _____

Relationship to member: ☐ spouse ☐ dependent child Date of birth Y M D _____

3. ATTENDING PHYSICIAN'S STATEMENT

Requested reference biologic drug _____ DIN _____ Dosage and frequency _____

Anticipated duration of drug therapy _____

Reason for the request:

☐ Pregnant patient – Due date: _____

☐ Pediatric patient: _____

☐ Patient for whom treatment with at least two other biologic drugs has failed for the same medical condition.
Please indicate the biologic drugs tried: _____

_____

☐ Other documented medical reason: _____

Physician's first name _____ Last name _____

Address _____ Postal code _____

Telephone _____ Fax _____ License number _____

Attending physician's signature _____ Date Y M D _____

4. MEMBER CONFIRMATION/AUTHORIZATION

I confirm that the information contained in this form is true and complete to the best of my knowledge.

On behalf of myself, or my dependent, if applicable, I authorize my physician or, if applicable, my dependent's physician, to exchange information with Industrial Alliance Insurance and Financial Services Inc., its employees, agents and service providers for the purpose of assessing my request for a brand name drug exception.

If the request for a brand name drug exception is in respect to my dependent, I confirm that I am authorized to disclose information about him/her with respect to the request.

If my Social Insurance Number is used for my certificate number, I authorize its use for the administration of my group insurance plan.

I agree that a photocopy of this Confirmation/Authorization is as valid as the original.

Member's signature _____ Date Y M D _____