REQUEST FOR PRIOR AUTHORIZATION
FREESTYLE LIBRE SENSOR (FREESTYLE LIBRE™)

GROUP INSURANCE

Please refer to page 3 for instructions

☐ **INITIAL CLAIM**

PART 1 - TO BE COMPLETED BY THE PLAN MEMBER / PATIENT

Member name: _____

Policy no.: _____ Certificate no.: _____

Patient name (if different): _____

Relationship to plan member: ☐ Spouse ☐ Dependent child Date of birth of the patient: Y Y Y Y M M D D

Is the patient covered by another group plan for the drug for which you are requesting authorization? ☐ Yes ☐ No

Are you receiving or have you applied for any financial assistance from another source (e.g. provincial or patient assistance program)? If yes, please provide copy of response. If no, please provide reason _____

_____

I agree that the statements included in this form will serve as a basis to review my own or my dependent's drug claim.

If the drug claim being reviewed is for my dependent, **I confirm** that I have the authorization to discuss the information about him or her with respect to the request.

On behalf of myself and my dependent, **I authorize** my physician or healthcare provider to disclose and exchange with Industrial Alliance Insurance and Financial Services Inc. (iA Financial Group) the information requested in this form regarding the drug for myself or my dependent. I consent to the release of the information contained in this claim form to iA Financial Group, its employees, agents, reinsurers, service providers and other organizations working with iA Financial Group for the purposes of the underwriting, administration and processing of this request.

If my Social Insurance Number is used as my identification number, I authorize its use for the administration of my group benefits.

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

X _____ Y Y Y Y M M D D

Member's signature Date

Address: no.:_____ street: _____ apt.:_____

City: _____ Province: _____ Postal code: _____

Home/cell phone : _____ Work phone: _____ Extension: _____

Email: _____

PART 2 - TO BE COMPLETED BY PRESCRIBING PHYSICIAN

☐ **FREESTYLE LIBRE 1 SENSOR**
☐ **FREESTYLE LIBRE 2 SENSOR**

1. Diagnostic or clinical situation
   - ☐ Self-monitoring of glycemia for diabetic person suffering from type 1 diabetes aged 17 and under
   - ☐ Self-monitoring of glycemia for a diabetic person aged 18 or over
   - ☐ Other. Please specify: _____
2. Insulin therapy
   - ☐ Intensive insulin therapy
     - ☐ Treatment by insulin pump
     - ☐ ≥ 3 insulin injections per day
       - — Fast-acting insulin: _____ Number of injections per day: _____
       - — Basal insulin: _____ Number of injections per day: _____
   - ☐ Other insulin regimen. Please specify: _____
3. Diabetes control
   Frequent episodes of hypoglycemia in the last year
   - ☐ Yes

     To prevent hypoglycemia, has the individual adhered to a blood glucose management plan?
     - ☐ Yes
     - ☐ No
   - ☐ No

Physician's first and last name (please print): _____

Address: no.:_____ street: _____ apt.:_____

City: _____ Province: _____ Postal code: _____

Telephone:_____ Fax: _____

Email: _____ License number: _____

☐ General practitioner ☐ Specialist ☐ Other, specify: _____

STAMP

X _____
Signature

Y Y Y Y M M D D
Date

For internal use

INSTRUCTIONS AND IMPORTANT INFORMATION

HOW TO FILL OUT THE FORM

Step 1: Plan member / patient must complete Part 1

Step 2: Prescribing physician must complete Part 2

⚠ IMPORTANT INFORMATION

— Any fees for the completion of the enclosed form are the responsibility of the plan member/patient.

— Your claims assessment will be delayed if the enclosed form is incomplete or contains errors.

— The purpose of the enclosed form is to obtain information required to assess your claim for a drug on iA Financial Group's Prior Authorization list. The drug must meet the criteria for coverage under your plan. In Quebec, drugs on the RAMQ Exception Drug list must also meet the criteria for coverage under your plan.

— Completion and submission of this form does not guarantee approval. You will receive reimbursement for the prior authorization drug only if the request has been reviewed and approved by iA Financial Group.

— You will be notified whether the request has been approved or denied. You can expect to receive notification within 10 days of when your request is received.

— To verify the status of the claim, log in to My Client Space.

HOW TO SUBMIT YOUR FORM

By fax (according to your province of residence):

Quebec
1-855-884-9811

All other provinces
1-877-780-7247

By Secure Messaging:
Log in to the My Client Space website and click on the white envelope at the top of the screen.

By mail (according to your province of residence):

Quebec
Health and Dental Claims Department
PO Box 800, Station Maison de la poste
Montreal QC H3B 3K5

All other provinces
Health and Dental Claims Department
PO Box 4643, Station A
Toronto ON M5W 5E3

If you have any questions, please contact Customer Service at 1-877-422-6487.

Business hours: Monday to Friday, 8 am to 8 pm (ET)