iA Financial Group

REQUEST FOR BRAND NAME 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 brand name 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. Otherwise your claim will be reimbursed at the cost of the lowest priced generic equivalent.

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 brand name drug _____ DIN _____ Dosage and frequency _____

Anticipated duration of drug therapy _____

Reason for the request: ☐ Documented allergic reaction – non-medicinal ingredient present in the generic drug, but absent in the brand name drug.

☐ Documented intolerance – non-medicinal ingredient present in the generic drug, but absent in the brand name drug:

_____

☐ Other documented medical reason: _____

PRIOR USE OF GENERIC DRUG

Has the generic drug been used? ☐ Yes ☐ No

If yes: Date drug therapy began Y M D _____ Date of adverse reaction Y M D _____

Describe nature, extent and severity of the adverse reaction _____

If no: Why has the generic drug not been used? _____

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 _____