iA Financial Group

# REQUEST FOR PRIOR AUTHORIZATION DRUGS

GROUP INSURANCE

**Please refer to page 2 for instructions**

☐ **Renewal** ☐ **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 ☐ Dependant child Date of birth of the patient Y M D _____

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

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. (the "Company") 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 the Company, its employees, agents, reinsurers, service providers and other organizations working with the Company 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.

**Member's signature X** _____ Date Y M D _____

Address _____ Postal code _____

Daytime phone _____ Extension _____ Member email _____

## PART 2 - TO BE COMPLETED BY PRESCRIBING PHYSICIAN

1. Drug name: _____ Dosage regimen: _____
2. Specify the medical condition warranting use of the aforementioned drug (diagnosis) _____
3. What is the expected duration of the treatment? _____
4. Provide a brief overview of the patient's current clinical status including stage and degree of severity _____
5. Provide a list of all previous and current drug treatments and their results (include all treatment programs) _____
6. Will the drug be administered in a hospital? ☐ Yes ☐ No
7. Are any alternative drug treatments available? _____
8. Is the patient enrolled in a clinical study for this drug? ☐ Yes ☐ No
   Has the patient ever been in a clinical study: ☐ Yes (drug name & study end date) _____ ☐ No
9. **Please provide a copy of the current consultation report** (or if renewal request, the most recent report) and/or any additional information that supports the use of this drug for this patient. _____

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

Address _____ Postal code _____

Telephone _____ Fax _____

Physician's email _____ License number _____

☐ General practitioner ☐ Specialist ☐ Other, specify _____

Signature **X** _____ Date Y M D _____

STAMP

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** | **All other provinces** |
|---|---|
| 1-855-884-9811 | 1-877-780-7247 |

**By mail** (according to your province of residence):

| **Quebec** | **All other provinces** |
|---|---|
| Health and Dental Claims Department<br>PO Box 800, Station Maison de la poste<br>Montreal, QC H3B 3K5 | Health and Dental Claims Department<br>PO Box 4643, Station A<br>Toronto, ON M5W 5E3 |

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

**Email:** groupinsurance@ia.ca

If you have any questions, please contact Customer Service at 1-877-422-6487.
Business hours: Monday to Friday, 7:30 am to 8:00 pm (ET)