iA Financial Group

REQUEST FOR BRAND NAME DRUG EXCEPTION

GROUP INSURANCE

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

☐ New request ☐ Renewal request

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

Complete the Member Information and Patient/Claimant Information sections of this form.
Take the form to your physician and ask him/her to complete the section entitled Attending Physician's Statement.
Return the completed form to iA Financial Group (address is above) in its role as administrator of your group policy.
Your request for the brand name drug exception will be reviewed and you will be informed, in writing, whether or not it has been approved.
You should not submit your claim before you receive your letter. 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 INFORMATION

Last name _____ First name _____

Policy no. _____ Certificate no. _____

Address _____ Apt. _____

City _____ Province_____ Postal code _____ Tel. _____

3. PATIENT/CLAIMANT INFORMATION

Last name _____ First name _____

Relationship to Member _____ Date of birth Y M D _____

Address (If different than above)_____ Apt. _____

City _____ Province_____ Postal code _____ Tel. _____

4. ATTENDING PHYSICIAN'S STATEMENT

Name of generic drug used _____ DIN _____ Dose _____

Date drug therapy began Y M D _____ Date of adverse reaction Y M D _____

Outcome attributed to adverse reaction (check all that apply)

☐ Allergic reaction ☐ Hospitalization ☐ Life threatening ☐ Required intervention to prevent impairment

☐ Other (please specify) _____

Describe nature, extent and severity of the adverse reaction_____

PROPOSED DRUG THERAPY - BRAND NAME DRUG _____ DIN _____ Dosage and Frequency_____

Anticipated Duration of Drug Therapy_____

Physician's last name _____ Physician's first name _____

License number _____ Address _____ Apt. _____

City _____ Province_____ Postal code _____ Tel. _____

Prescriber's Signature _____ Date Y M D _____

5. 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 benefits.

I agree that a photocopy of this authorization is as valid as the original.

Member's Signature _____ Date Y M D _____

iA Financial Group is a business name and trademark of
Industrial Alliance Insurance and Financial Services Inc.