AUTHORIZATION REQUEST
Exception drug – personalized coverage program

F13-1109A

1. TO BE COMPLETED BY THE PLAN MEMBER/PATIENT

Name: _____ Date of birth: Y Y Y Y M M D D

Name of insurer: _____ Group and certificate number: _____

Patient name (if different): _____ Date of birth: Y Y Y Y M M D D

Address: _____ Postal code: _____

Phone no.: _____ Email address: _____

Are you receiving or have you applied for any financial assistance from another source (e.g. provincial or patient assistance program)? ☐ Yes ☐ No

If yes, please provide a 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 am authorized to discuss the information about him or her with respect to the claims. 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 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.

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

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

2. TO BE COMPLETED BY PRESCRIBING PHYSICIAN (DOCTOR, RESIDENT DOCTOR OR SURGEON DENTIST)

Name of prescriber: _____ "Régie" application no.: _____

Address: _____ Postal code: _____

Phone no.: _____ Fax no.: _____

Email address: _____

Identification of medication requested (**IMPORTANT :** Use a **separate** form for **each** medication)

Name of medication:	Form:	Potency:	Duration of treatment from: Y Y Y Y M M D D to: Y Y Y Y M M D D
Dosage:			Will the drug be administered in a hospital? ☐ Yes ☐ No

Justification of the requisition (Indicate any relevant information useful to assessment)

Diagnosis:

Signature of prescriber **X** _____ Date: Y Y Y Y M M D D

YOU CAN SEND YOUR FORM:

By mail: iA Financial Group Claims Department
1611 Crémazie Blvd. East, Suite 900
Montreal, QC H2M 2P2

By fax: 1-877-627-9313