Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardins.com/planmember
1-800-263-1810

REQUEST FOR REIMBURSEMENT OF BRAND NAME MEDICATIONS

- Charges for completing this form are at the plan member's expense.
- The brand name medication for which you are requesting an exception is covered up to the price of the lowest cost generic equivalent available on the market. If this exception is approved, the medication will be covered at the price of the brand name medication.
- Please complete sections A and B and have your physician complete sections C and D. The exception will only be approved if the physician provides an acceptable medical reason explaining why the patient is unable to take the lowest cost generic equivalent available on the market. This request will be assessed based on the medical information provided and may be reviewed by our physician or pharmacist.

Section A. Patient's information – To be completed by the plan member.

Name of policyholder | Group No. | Certificate No.

Last and first name of plan member | Date of birth YYYY MM DD

Address – No., street, apt. | City | Province | Postal code | Phone number

Last and first name of patient | Date of birth YYYY MM DD

Relationship to plan member | DIN (Drug Identification Number)

Section B. Declaration and authorization for the collection, use and communication of personal information

All the information I have provided on the claim form is accurate and complete. I acknowledge having read the Personal Information Management section at the back of the form. I authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, strictly for the purposes of managing my file and settling this claim to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, insurance companies; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, use the personal information it may have about me in existing files that are now closed. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of plan member _____ **Date** _____

Signature of insured dependent aged 16 and over _____ **Date** _____

Section C. Physician's statement – To be completed by the physician.

1. What is the diagnosis? _____

2. Brand name medication requested:
   Name and strength _____ DIN _____
   Dosage _____

3. Generic drug tried:
   Name and strength _____ DIN _____
   Dosage _____ Treatment period: From _____ To _____

4. What is the medical reason for the request? ☐ Allergies / Intolerance ☐ Other _____
   Please specify the severity and nature of the health problem and its consequences for the patient _____
   Provide objective data and relevant clinical test results justifying the return to the brand name medication _____

Section D. Physician's identification – To be completed by the physician.

Last and first name of attending physician (PLEASE PRINT):

Address – No., street, suite | City | Province | Postal code

Phone No. | Fax No.

Signature of attending physician: **Date:**

Section E. Personal information management

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentation, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.

Choose one of the following options to send us this form or any other required documents.
Keep a copy for your records.

Online

1. Go to desjardins.com/planmember and click on **Log in to your account**.
2. Enter your user ID and password to log in to your group insurance file.
3. In the **Tools and resources** tab, select *Send documents*, then click on **Start.**
4. In the **Type of insurance** drop-down menu, select *Health insurance*.
5. In the **Type of document** drop-down menu, select *Forms*.
6. In the list under **Document Name**, select *Prior Authorization Request – Drugs.*
7. Attach your documents and complete your submission.

By mail

Desjardins Insurance
Group Insurance, Health Claims
C. P. 3950
Lévis (Québec) G6V 8C6

By fax

418-838-2134

1-877-838-2134 (toll-free)

PRINT NEW REQUEST