Desjardins Insurance
Life • Health • Retirement

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

PRINT NEW REQUEST

REQUEST FOR REIMBURSEMENT OF A MEDICATION NOT INCLUDED ON THE TIER 1 DRUG LIST

Important Information

- Charges for completing this form are at the plan member's expense.
- The plan member must complete sections A and C.
- The medication for which you are requesting an exception is not included on the Tier 1 drug list. If this exception is approved, the medication will be reimbursed at a higher percentage than the current one. The exception will only be approved if the attending physician provides a valid medical reason why the patient is unable to take a therapeutic alternative listed on the Tier 1 drug list.
- The attending physician must complete sections D and E.
- This request will be analysed based on the medical information provided and may be reviewed by one of our consulting physicians or pharmacists.

Section A. Patient identification (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

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

Relationship to plan member	DIN (Drug Identification Number)

Section B. 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 Financial Security Life Assurance Company, hereinafter 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.

Section C. 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. I authorize 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 and 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) use the personal information it may have about me in existing files that are now closed, when necessary.

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 X _____ **Date** _____

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

Phone Nos: Home _____ **Office** _____ **Extension** _____

Please have your attending physician complete the back of the form.

Section D. Declaration of attending physician (to be completed by the physician)

1. What is the diagnosis? _____

2. Medication requested:

Name and strength _____ DIN _____

Dosage _____

3. Alternative medication listed on the Tier 1 drug list that the patient has tried:

Name and strength _____ DIN _____

Dosage _____ Treatment period: From _____ To _____

4. What is the medical reason for the request? ☐ Allergies ☐ Adverse reaction ☐ Therapeutic failure

☐ Other _____

The effects attributable to the adverse or allergic reaction are:

☐ Mild (no intervention required)

☐ Moderate (minimal intervention required)

☐ Severe (hospitalization required)

☐ Life threatening

Describe the adverse or allergic reaction observed (nature, extent, severity) _____

_____

_____

Section E. Physician identification (to be completed by the physician)

Last and first name of physician (PLEASE PRINT)

_____

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

_____

Phone No. | Fax No.

Signature of attending physician X _____ **Date** _____

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

Online

1. Go to desjardins.com/planmember and click **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 **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 fax

418-838-2134
1-877-838-2134 (toll-free)

By mail

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