iA Financial Group

PRIOR AUTHORIZATION FORM

GROUP INSURANCE

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

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5
Fax: 1 855 884-9811

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7
Fax: 1 877 780-7247

Print

This form is to obtain information required to assess your claim for a drug on the Industrial Alliance *Prior Authorization* list. The drug must satisfy the criteria for coverage under your plan. In Quebec, if it is a drug covered under the RAMQ *Exception Drug list*, it must meet the criteria for coverage under that program, as well.

PART 1 – MEMBER/PATIENT INFORMATION

Member name _____

Policy no. _____ Certificate no. _____

Patient name (if different) _____

Relationship to plan member _____ Date of birth Y M D _____

PART 2 – TO BE COMPLETED BY PHYSICIAN

1. Drug name: _____ Daily dosage: _____

2. What is the expected duration of the treatment? _____

3. Specify the medical condition warranting use of the aforementioned drug _____

4. Provide a brief overview of the patient's current clinical status _____

5. Provide a description of the previous treatment program and its results _____

6. Indicate where the medication will be administered

☐ Home (self-administered) ☐ Hospital ☐ Private clinic ☐ Other, specify _____

7. Are any alternative drug treatments available? _____

8. Are there any other sources of funding available for this medication? (e.g.: Ministry of Health, special drug program, charitable organization, etc.) _____

9. Is a specialist involved in the treatment? ☐ Yes ☐ No If yes, please provide a copy of the consultation report.

10. Provide any additional information that supports the use of this drug for this patient _____

Physician's last and first name _____

Address _____ Postal code _____

Telephone _____ Fax _____

Email _____

☐ General practitioner ☐ Specialist ☐ Other, specify _____

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

PART 3 – MEMBER CONFIRMATION/AUTHORIZATION

I agree that the statement 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 drug claim.

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 underwriting, administration and processing of the drug claim.

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 _____

Tel. home _____ Tel. work _____ Extension _____