MEDAVIE BLUE CROSS™

REQUEST FOR BRAND NAME DRUG COVERAGE

To be eligible for coverage for the brand name drug requested, there must be medical evidence indicating that a true adverse reaction has occurred. Please refer to Health *Canada's Canada Vigilance Adverse Reaction Reporting form* for Health Canada's definition of a true adverse reaction.

For this request to be processed, please complete the following:

TO BE COMPLETED BY PATIENT (PLEASE PRINT)

Member Name	Group & Section Number	Identification Number
Patient Name	Relationship to Member ❑ Member ❑ Spouse ❑ Dependent	Patient Date of Birth (DD/MM/YYYY)
Street Address		Telephone Number ( ) -
City	Province	Postal Code

I hereby authorize any health care provider to release to Medavie Blue Cross, any medical information about myself and my dependents which relates to claims submitted by us, or on our behalf, to Medavie Blue Cross. I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross' business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, healthcare professionals, or institutions, life and health insurers, government and/or regulatory authorities, the member of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature of Patient	Date (DD/MM/YYYY)

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information or privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call our Customer Contact Centre at 1-800-667-4511.

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROFESSIONAL

Physician Name (please print)	Physician Telephone Number
Drug Name	

❑ I have completed a **Health Canada Vigilance Adverse Reaction Reporting Form** and sent to Health Canada.

❑ I have enclosed a copy of the completed, signed and sent **Health Canada Vigilance Adverse Reaction Reporting Form**.

Signature of Physician/Healthcare Professional	Date (DD/MM/YYYY)

Your request may be delayed if information is incomplete or contains errors. Any costs incurred for the completion of this request are the responsibility of the patient. Completed requests can be submitted as follows:

For Atlantic/Ontario

Fax: 1-800-670-2899 (Confidential Line)

Mail: Private and Confidential - Medavie Blue Cross
c/o Special Authorization, Prescription Drugs
P.O. Box 220, Moncton, NB E1C 8L3

For Quebec

Fax: 1- 514-286-7643 (Confidential Line)

Mail: Private and Confidential - Medavie Blue Cross
c/o Special Authorization, Prescription Drugs
C. P. 3300 Succursale B, Montreal, QC H3B 4Y5

If you wish to know the status of your request, please call our Customer Contact Centre at 1-800-667-4511 for Atlantic/Ontario, and 1-888-588-1212 for Quebec.