Desjardins Insurance
Life • Health • Retirement

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

REQUEST FOR REIMBURSEMENT OF A MEDICATION NOT INCLUDED IN THE DYNAMIC THERAPEUTIC FORMULARY (DTF) OR OF A BRAND NAME MEDICATION

Important information

- Any charges for the completion of this form are the member's responsibility.
- The member must complete sections A and C.
- If the request is for the reimbursement of a medication that is not included in the DTF, the attending physician must complete sections D and F. If the request is for the reimbursement of a brand name medication, the attending physician must complete sections E and F. The member must have read and understood the instructions provided in these sections.
- This request will be assessed based on the medical information provided and may be reviewed by our physician or pharmacist.

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

Name of policyholder	Group no.	Certificate no.

Last name and first name of member	Sex ☐ M ☐ F	Date of birth YYYY MM DD

Address- No., street, apt.	City	Province	Postal code

Last name and first name of patient	Sex ☐ M ☐ F	Date of birth YYYY MM DD

Relationship to member	DIN (Drug Identification Number)

Section B – Personnal 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 documentations, 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, 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 member _____ **Date:** _____

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

Telephone Nos: Home: Office: Extension:

PLEASE HAVE YOUR ATTENDING PHYSICIAN FILL OUT THE BACK OF THIS FORM.

PRINT NEW REQUEST

Section D – Medication not included in the Dynamic Therapeutic Formulary (DTF) – Declaration of attending physician – To be completed by the physician.

- The medication for which you are applying for an exception is not included in the DTF and is currently covered at a lower percentage. If this exception is approved, the medication will be covered at a higher percentage.
- The exception will only be approved if the physician provides an acceptable medical reason to support why the patient is unable to take a therapeutic alternative listed in the DTF.
- The approved medication will be covered up to the lowest cost generic equivalent available on the market. If the patient cannot take the generic equivalent either, another acceptable medical reason will need to be provided in section E.

1. What is the patient's diagnosis? _____

2. Drug requested:

Name and strength: _____ DIN: _____

Dosage: _____

3. Alternative drug listed on the DTF 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

Please describe the adverse or allergic reaction observed (nature, extent, severity): _____

_____

_____

Section E – Brand name medication – Declaration of attending physician – To be completed by the physician.

- The brand name medication for which you are applying for an exception is currently covered up to the lowest cost generic equivalent available on the market. If this exception is approved, the medication will be covered at the price provided for the brand name medication.
- The exception will only be approved if the attending physician provides an acceptable medical reason to support why the patient is unable to take the lowest cost generic equivalent available on the market.

1. What is the patient's diagnosis? _____

2. Brand name drug 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 ☐ 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

Please describe the adverse or allergic reaction observed (nature, extent, severity): _____

_____

_____

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

Last name and first name of physician (PLEASE PRINT)

_____

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

_____

Telephone no.: | Fax no.:

Signature of physician: **Date:**

Send form by fax: 418-838-2134 or 1-877-838-2134
or by mail: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6