THE Great-West Life ASSURANCE COMPANY

Prior Authorization Form for Medical Cannabis

The purpose of this form is to obtain information required to assess your claim for medical cannabis.

To be eligible for coverage, medical cannabis must represent reasonable treatment for the condition upon which your claim is based. Approval for coverage of medical cannabis may be reassessed at any time at Great-West Life's discretion.

If approved, the effective date of coverage will be the date coverage was approved by Great-West Life. Requests for coverage prior to the approval date will be considered on an exception basis only.

[Note that some Great-West Life group benefit plans may require you to purchase a drug from a pharmacy designated by Great-West Life. If this is the case for your group benefit plan, the designated pharmacy will be communicated to you.]

IMPORTANT: Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

Any costs incurred for the completion of this form are the responsibility of the plan member/patient.

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect is used for the purposes of assessing eligibility for medical cannabis and for administering the benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), refer to www.greatwestlife.com or write to Great-West Life's Chief Compliance Officer.

I authorize Great-West Life, any healthcare provider, my plan administrator (if applicable), any insurance or reinsurance company, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for medical cannabis and to administer the benefits plan. I acknowledge that providing my consent will help Great-West Life to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's signature: _____ Date: _____

Form Completion Instructions:

1. **Complete "Patient Information" sections.**
2. **Have the prescribing physician complete the "Physician Information" sections.**
3. **Send all pages of the completed form to us by mail, fax or email as noted below.**

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to: **The Great-West Life Assurance Company**
Drug Services
PO Box 6000
Winnipeg MB R3C 3A5

Email to: **gwldrug.services@gwl.ca**
Attention: Drug Services

Fax to: **The Great-West Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Services

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THE Great-West Life ASSURANCE COMPANY

Patient Information
Medical Cannabis

Plan Member Information – Complete all sections of this page (please print)

Plan Member:	Patient Name:	
Plan Name:	Plan Number:	Plan Member ID Number:
Patient Date of Birth (DD/MM/YYYY):	Address (number, street, city, province, postal code):	

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient.

May we contact you by email? (Note that some correspondence may still need to be sent by regular mail).

☐ Yes ☐ No If yes, please provide email address: _____

Do you have coverage of medical cannabis with another carrier? ☐ Yes ☐ No

If Yes, a) indicate start date: (DD/MM/YYYY) _____

b) coverage provided by: _____

Please have your treating physician complete the "Physician Information" section.

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THE Great-West Life ASSURANCE COMPANY

Physician Information
Medical Cannabis

Physician's Information (please print)

Name of prescribing physician:

Specialty:

Address (number, street, city, province, postal code):

Telephone Number (including area code):	Fax Number (including area code):

1. Product Name: Medical Cannabis
2. Is your patient authorized to possess cannabis for medical purposes under current legislation? ☐ Yes ☐ No
3. Prescribed dosage form and regimen: _____
4. Diagnosis / Indication for use (include date of initial diagnosis) (MM/YYYY): _____
   - ☐ Spasticity or neuropathic pain associated with multiple sclerosis
   - ☐ Chemotherapy-induced nausea and vomiting or neuropathic pain associated with cancer
   - ☐ Anorexia or neuropathic pain associated with HIV/AIDS
   - ☐ Symptoms associated with palliative care
5. What is the anticipated duration of treatment with medical cannabis? _____

I certify that the information provided is true, correct, and complete.

Physician's Signature: _____ Date: _____

License Number: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for medical cannabis. The completed form can be returned to Great-West Life by mail, fax or email.

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Drug Services
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