Quebec Exception Patient Program Form

The purpose of this form is to obtain information required to assess your drug claim.

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.

Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to www.canadalife.com or write to Canada Life's Chief Compliance Officer.

I authorize Canada Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient assistance programs or other benefits programs, other organizations, or service providers working with Canada 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 this drug and to administer the group benefits plan. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I also consent to the use of my personal information for Canada Life and its affiliates" internal data management and analytics purposes.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given below is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

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 Quebec Patient and Exceptional Medicine Form / medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to: **The Canada Life Assurance Company**
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: **The Canada Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to: **cldrug.services@canadalife.com**
Attention: Drug Claims Management

For additional information regarding Quebec Exception Patient Program, please visit our Canada Life website at www.canadalife.com or contact Group Customer Contact Services at 1-800-957-9777. Deaf or hard of hearing and require access to a telecommunications relay service? Please contact us at 711 for TTY to Voice or 1-800-855-0511 for Voice to TTY.

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Patient Information

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: _____

Tell us if you have been on this drug before

Is the patient currently on, or previously been on this drug? ☐ Yes ☐ No

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

b) coverage provided by: _____

(if coverage is not provided by Canada Life please provide pharmacy print-out showing purchase of this drug)

Tell us if you have coverage with any other benefits plan

Does the patient have drug coverage under any other group benefits plan? ☐ Yes ☐ No

If Yes, name of other Insurance Company: _____

If other plan is with Canada Life, tell us the plan and ID number: _____

Name of plan member: _____

Relationship to patient: _____

Provide details and attach documentation of acceptance or declination:

_____

_____

Tell us about any Provincial or other coverage you may have

Does the patient have coverage under a provincial program or from any other source? ☐ Yes ☐ No

If Yes, name of program or other source: _____

Provide details and attach documentation of acceptance or declination: _____

Is the patient currently receiving disability benefits for the condition for which this drug has been prescribed? ☐ Yes ☐ No

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Physician Information

Note to Physician: In order to assess a patient's claim for this drug, we require detailed information on the patient's prescription drug history as requested below.

Attach extra information if necessary. *GENETIC TEST RESULTS ARE NOT REQUIRED*

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.Name of drug prescribed: _____

2. Prescribed dose and regimen: _____

3. Patient's weight: _____ kg (for weight-based dosing) Date determined (MM/YYYY): _____

4. Anticipated duration of treatment with this drug: _____

Start Date (DD/MM/YYYY) _____ End Date (DD/MM/YYYY) _____

5. Where will treatment be administered? ☐ Home ☐ Physician's Office ☐ Private clinic ☐ Hospital in-patient ☐ Hospital out-patient

6. Diagnosis and Therapeutic Indication: _____

7. Therapeutic Goal: _____

8. Date of onset of the symptoms, complications, or manifestations of the disease: _____

_____

9. If the treatment with the drug requested has already started, please answer by considering the patient's condition at the start of treatment.

Specify the degree of functional limitation in relation to the diagnosis:

Types of Activities	Degree of limitation*
Physical activities (walking, climbing stairs, lifting objects, etc.)	
Daily activities at home (personal hygiene, meal preparation, cleaning, etc.)	
Daily activities outside the home (employment (gainful or not), school attendance, errands, leisure activities, sports, etc.)	
Social activities (restaurants, movies, visits to family members, volunteer work, etc.)	

(*) Legend:
0 = no limitation
1 = slight limitation
2 = moderate limitation
3 = severe limitation
4 = extreme limitation

10. In the absence of physical functional impairments, is there a risk that the progression of this person's condition or its complications could have repercussions on their condition in terms of morbidity or mortality? ☐ Yes ☐ No

If yes, specify: _____

_____

11. If this person has psychological functional impairments arising from the condition to be treated, please describe and provide details of their severity:

_____

_____

12. If a severity scale exists for the condition, or examination results are available, please provide them (e.g.: visual analogue scale). If this is regarding a symptom, please describe its intensity, frequency and duration:

_____

_____

Physician Information

13. Was an investigation by a specialist performed? Specify: _____

Attach results of relevant clinical examinations, including investigation reports by a specialist, if applicable (e.g.: imaging, T score, laboratory test results).

14. Specify the medical treatments and drugs received to treat this condition, dosages, duration of treatment, and the reason for discontinuing:

15. What other drugs and medical treatments recognized as effective for the treatment of this condition cannot be prescribed because of conditions specific to this case? Specify: _____

16. If the treatment with the requested drug has already started, specify the start date and the beneficial effects observed:

17. Please provide any other relevant clinical information. _____

18. For continuation of an authorization that was previously approved by RAMQ, specify the beneficial effects of this drug since the start of treatment:

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

Physician's Signature: _____ Date: _____

License Number: _____

Refer to RAMQ's List of Medications document when providing detailed information. It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit. The completed form can be returned to Canada Life by mail, fax, or email.

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.

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Drug Claims Management
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Winnipeg MB R3C 3A5

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