Drug exception application form

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping information concerning this application confidential.

1 Important – please read carefully

Sometimes it may be medically necessary for your physician to prescribe a drug that is not covered, not fully covered or that requires more frequent dispensing than is currently eligible under your plan. If this is your situation, you can request that Sun Life Assurance Company of Canada make an exception.

Exceptions will only be made for drugs which legally require a prescription.

If you have already purchased the medication for which you are requesting an exception, please attach all original receipts along with a regular extended health care claim form.

Please note that the completion of this form is not a guarantee of approval. It must be completed in full, otherwise it will be returned to you. Any expense for medical evidence to support this request is your responsibility.

2 Plan member information

Please have your physician complete the reverse side of this form.

To be completed by plan member

Contract number	Member ID number	Your plan sponsor/employer		
Your last name		First name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Your address (street number and name)				Apartment or suite
City			Province	Postal code
Preferred language of correspondence ☐ English ☐ French		Daytime phone number	Fax number or e-mail address	

3 Patient information

If the patient is the plan member, do not complete this section. The patient is the person for whom you are making the claim.

Last name	First name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Relationship to plan member ☐ Spouse ☐ Child			Full-time student ☐ Yes ☐ No

Please check any box that applies to the patient:

☐ The patient is an over-age student dependent (i.e. attending University or College full-time). A copy of the enrolment document from the educational institution confirming full-time status is enclosed.

☐ The patient is a spouse or a dependent over age 18. The patient has signed the authorization section below that allows Sun Life to obtain the additional medical information pertaining to this request.

4 Coordination of benefits

To be completed by plan member

Complete this section if you and your spouse are covered under ***different*** benefit plans. Send your request to the **primary plan** first. If Sun Life is the secondary plan, please attach the primary plan's response, as well as the claim statement, to this form. We need both to process this request.

If the patient is a dependent, their primary plan is the same as the parent whose birthday is first in the calendar year. For example, if you have a June birthday, and your spouse has a July birthday, your plan is the primary plan.

Is the patient (plan member or dependent) covered under another benefit plan? ☐ Yes ☐ No

If yes, please provide details below of the person whose benefit plan covers the patient.

Last name		First name	
Date of birth (dd-mm-yyyy)	Relationship		Type of coverage ☐ Single ☐ Family
Name of insurance company		Contract number	Member ID number

Is this drug covered under the primary plan? ☐ Yes ☐ No

If your other benefit plan is with Sun Life, do you want us to process this form through both benefit plans? ☐ Yes ☐ No

Signature of covered family member	Date (dd-mm-yyyy)
X	

5 Authorization and signature

To be completed by plan member

The answers on this form are true. I allow Sun Life to collect, use and disclose my personal information for three reasons. These reasons are plan administration, underwriting coverage and assessing claims. Sun Life may share (meaning collect and disclose) information with healthcare providers, hospitals, clinics, pharmacies, government programs, patient assistance programs, and any other organization with relevant information about me. Sun Life may also share information with insurers or reinsurers, and agents and service providers of Sun Life and the above parties. Sun Life will share my information only when necessary. My consent applies while this plan is in effect.

I agree that a photocopy or electronic version of this authorization is as valid as the original.

Plan member's signature	Date (dd-mm-yyyy)
X	
Patient's signature (if over 18 years of age) X	Date (dd-mm-yyyy)

6 Prescriber information

To be completed by prescribing physician

Prescribing physician's last name (please print)		First name (please print)	
License number			
Specialty		Telephone number	Fax number
Address (street number and name)			Apartment or suite
City		Province	Postal code

7 Provincial drug program

To be completed by prescribing physician

Has an application been made to the provincial program for this drug? ☐ Yes ☐ No

If yes, name of the program	Date of application (dd-mm-yyyy)

Please provide any documentation indicating the province's decision

☐ Provincial response letter

☐ Provincial special authorization form

☐ Other: ____________________

If no, please explain why application has not been made

8 Drug information

To be completed by prescribing physician

Drug name and strength(s)	DIN(s)
Dose, route of administration, and frequency	Treatment start date (yyyy-mm-dd)

☐ New request or ☐ Renewal request	Anticipated duration of therapy

List the medical condition(s) being treated with this drug. Do not include genetic test results or reference to genetic mutations.

Indicate where the drug will be administered

☐ Home
☐ Hospital: in patient (provide name and address below)
☐ Hospital: out patient (provide name and address below)
☐ Private clinic (provide name and address below)
☐ Doctor's office

Name of hospital or private clinic		
Address (street number and name)		Apartment or suite
City	Province	Postal code

Please select reason for this request (choose one):

Sometimes it may be medically necessary to prescribe a drug that is not covered, not fully covered or that requires more frequent dispensing than is currently eligible under the patient's plan. If this is the situation, the patient may request an exception from Sun Life by completing this form. Drug exceptions for prescription drugs are only considered if the drug is being used for a medical condition that is an approved indication according to Health Canada.

☐ If the patient is unable to take the lower priced equivalent drug and you're requesting the full cost of the drug to be eligible under their plan, please complete part A.

☐ If the patient is unable to take an alternate drug available at a higher reimbursement level and you're requesting the highest reimbursement level under the patient's plan, please complete part B.

☐ If you're requesting the additional dispensing fee to be covered, please complete part C.

☐ If you're requesting coverage for a drug not covered under the patient's plan, please complete part D.

8 Drug information (continued)

Complete the applicable section below. Please do not provide any genetic test results.

Part A: Patient is unable to take the lower priced equivalent drug

Medical reason for requesting drug exception

☐ Contraindication to the lower priced equivalent drug
☐ Severe adverse reaction to the lower priced equivalent drug
☐ Therapeutic failure of the lower priced equivalent drug
☐ the lower priced equivalent drug has drug-drug interactions with other drugs patient is on
☐ Other (please specify) ____________________

Describe the nature, extent and severity of the above reason. If drug-drug interactions, please identify the other drugs and nature of the interaction.

I hereby confirm that I am the prescribing doctor and that the information set out above is true and complete

Physician's signature X	Date (yyyy-mm-dd)

Part B: Patient is unable to take alternative drug(s) available under a higher reimbursement level

For the requested drug to be eligible for coverage, trials with two alternative drugs covered by the patient's plan may be required. List other drugs the patient has used, is using or cannot use for this medical condition:

Drug & dose	Dates of therapy, if applicable	List medical reason(s) for not using	Describe nature and severity of reason.
		☐ contraindication ☐ severe adverse drug reaction ☐ therapeutic failure ☐ drug-drug interaction ☐ other ________	
		☐ contraindication ☐ severe adverse drug reaction ☐ therapeutic failure ☐ drug-drug interaction ☐ other ________	

I hereby confirm that I am the prescribing doctor and that the information set out above is true and complete

Physician's signature X	Date (yyyy-mm-dd)

Part C: Additional dispensing fee to be covered

Medical reason for requesting dispensing fee frequency exception:

☐ Patient safety ☐ Treatment monitoring
☐ Other (please specify) ____________________

I hereby confirm that I am the treating and prescribing doctor and that the information set out above is true and complete

Physician's signature X	Date (yyyy-mm-dd)

Part D: Coverage for a drug not covered under claimant/patient's plan

Initial request

Please provide the following information. Do not provide any genetic test results.

☐ Date of diagnosis ____________

☐ Clinical details regarding patient's current condition including symptoms, signs, and prognosis

8 Drug information (continued)

☐ Details of previous treatments (including drug name, dose, dates of treatments and reasons for discontinuation) or details of contraindications to alternate treatments

Drug & dose	Dates of therapy	Reasons for discontinuation

☐ What are the goals of therapy with requested drug and how are the goals monitored?

☐ If the patient receive the requested drug in the past, please provide details including dose, dates of treatments, objective evidence of benefit and reasons for stopping treatment

I hereby confirm that I am the prescribing doctor and that the information set out above is true and complete

Physician's signature X	Date (yyyy-mm-dd)

Renewal request

☐ There is documented evidence of clinical benefit. Describe how treatment goals identified in the initial request have been met

I hereby confirm that I am the prescribing doctor and that the information set out above is true and complete

Physician's signature X	Date (yyyy-mm-dd)

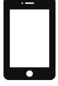
9 Respecting your privacy

Respecting your privacy is a priority for the Sun Life group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Questions? Please visit *www.sunlife.ca* or call toll-free 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

10 Send us your form

All pages of this form must be submitted together. Keep a copy for your records.



You can submit **all** pages of this form through the mobile app. Please use 'drug exception' as the reference number.

OR,

Mail or fax all completed pages of the form to the claims office nearest you.

Fax number: 1-855-342-9915

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Montreal QC H3C 6C1

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