UV INSURANCE

GROUP INSURANCE

Payment Authorization Request

Exception Prescription Drug

Important: All 3 pages must be completed for the application to be processed. The physician's signature is required.

Section A—Member Identification (Contract Holder)

1. Certificate # _____ Group # _____
2. First name _____ Last name _____
3. Date of birth |__|__|__|__|__|__|__|__|

Section B—Patient Identification

1. First name _____ Last name _____
2. Date of birth |__|__|__|__|__|__|__|__|
3. Address _____ App. # _____
   City _____ Province _____ Postal code |__|__|__|__|__|__|
4. Telephone |__|__|__|__|__|__|__|__|__|__| 5. Work |__|__|__|__|__|__|__|__|__|__| Ext. _____
6. Email _____
7. Relationship to member (contract holder) ☐ Member ☐ Spouse ☐ Dependent child
8. **Name of drug** _____ 9. **Name of physician** _____

Other Insurance Medication Coverage

Provincial Plan

Are you covered by a provincial plan (e.g., RAMQ)? ☐ No ☐ Yes

If so:
- Please provide a copy of the form submitted → ☐ Copy attached to present form
- Please provide a copy of the approval or refusal → ☐ Copy attached to present form

Private Plan

Are you covered by another private drug insurance plan? ☐ No ☐ Yes

If so:
- Name of the private insurer _____
- Please provide a copy of the form submitted to the other insurer → ☐ Copy attached to present form
- Please provide a copy of the approval or refusal → ☐ Copy attached to present form

Section C—Collection, Use and Disclosure of Personal Information

Your consent to the collection of your personal information is required for UV Insurance to evaluate this request and communicate with relevant health care professionals (e.g., your pharmacists, attending physicians, nurses, pharmacy technicians, and nutritionists), health care institutions, insurance companies, government authorities, government programs, and patient support programs.

I consent to the above-mentioned third parties providing UV Insurance with the necessary information to assess my claim. This includes my medication profile, medical conditions, blood test results, imaging reports, medical scores, pharmacy contact details, drug coverage details from previous insurers, and information from my Québec Health Record (QHR). I also authorize UV Insurance to share this information with the above-mentioned third parties. UV Insurance will only collect and disclose personal information strictly required for the analysis of this claim.

I understand that this consent also applies to my dependents if they are the subject of this application and that I certify that I have obtained their authorization.

Please note that you may withdraw your consent to the disclosure or use of your personal information at any given time. However, withdrawing your consent may have legal or contractual consequences in the administration of your insurance contract. UV Insurance will explain such consequences to you. To request correction of your information (which may be inaccurate, incomplete or outdated), please consult your file. To withdraw your consent, submit a written request to the attention of the UV Insurance Privacy Officer at the following mailing address: 1990 Jean-Berchmans-Michaud St., Drummondville (Quebec) J2C7G7.

For more information, please consult the Privacy Policy of UV Insurance at https://uvinsurance.ca/privacy-policy/

X _____ Date |__|__|__|__|__|__|__|__|

Patient's Signature

EN-5036A (2024-12)

Section D—Physician Identification and Declaration

To be completed by the physician

1. First name _____ Last name _____
2. License # _____
3. Address _____
   City _____ Province _____ Postal code _____
4. Telephone _____-_____ Ext. _____ 6. Fax _____-_____

Type of Request

☐ Initial request ☐ Change of treatment request ☐ Renewal request

Please fill out all sections below to ensure that the review is carried out as quickly as possible.

Drug Requested

1. Drug name _____ 2. Form _____ 3. Potency _____
4. Dosage _____ 5. Weight _____ 6. Size _____
7. Expected treatment duration from _____ to _____

- Please complete all sections to avoid delaying the processing of your request. Please note that the form will be returned to you if any information is missing.
- The application must be accompanied by clinical studies or other documentation justifying the use of the drug for the requested indication.
- Please send us the information required to process your request (e.g., scores, test results, lab values, imaging report, severity of the condition).

Diagnosis

Justification of the Request

Note: For certain drugs, enrollment in a patient support program may be required in order for the reimbursement of the requested drug.

Patient Support Program (PSP)

1. Is the patient enrolled in a patient support program? ☐ No ☐ Yes **If so, please answer the following questions:**
2. Name of the program _____ 3. Name of the resource person _____
4. Telephone _____-_____ Ext. _____ 5. Fax _____-_____

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Summary of Previous Trials

1. Please indicate all previous drug trials. Provide the duration of treatment(s) as well as the reason for their termination.

	Drug 1	Drug 2	Drug 3
Name			
Dosage			
Reason	☐ Ineffectiveness ☐ Contraindication ☐ Intolerance ☐ Other, specify _____	☐ Ineffectiveness ☐ Contraindication ☐ Intolerance ☐ Other, specify _____	☐ Ineffectiveness ☐ Contraindication ☐ Intolerance ☐ Other, specify _____
Duration	from ⌊ ⌋ to ⌊ ⌋	from ⌊ ⌋ to ⌊ ⌋	from ⌊ ⌋ to ⌊ ⌋

2. Please indicate any additional information relevant to the evaluation of this request.

Section E—Renewal of Payment Authorization Request

To be completed by the physician

1. Name of drug _____ 2. Dosage _____

3. Please provide details of any clinical benefits observed following treatment.

4. Please provide the most recent clinical results and evidence of response to treatment.
(e.g., scores, test results, lab values, imaging report).

Section F—Signature

I certify that the information provided in this request is accurate.

X _____ License # _____ Date ⌊ ⌋

Physician's Signature