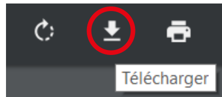
Steps to complete the form

1

Click on the download button for save the form on your computer.



2

Fill in the fields of the form and save your information before submitting it to us.

UV INSURANCE

Prior Authorization Request
Exception prescription drug

Important: Fill out in block letters and answer each section as accurately as possible.

Section A — Prescriber information

1. First Name ______ Last Name ______
2. Provincial Health Program Registration nº ______
3. Address ______
   City ______ Province ______ Postal code
4. Telephone -   5. Fax -

Section B — Patient information

Patient/Insured member

1. Certificate nº   Group nº
2. First Name ______ Last Name ______
3. Date of birth Y Y Y Y M M D D
4. Address ______
   City ______ Province ______ Postal code
5. Telephone -   6. Other -

Coordination of benefits

1. Are you or any of your insured dependants covered by another insurance or by a program (ex: Government program, RAMQ, OHIP...) for the drug requested? ☐ Yes ☐ No
   If so, please provide the following information:
   a) Policy nº ______ **b)** Name of the insurer ______
   c) If it is for one of your dependants, please indicate the day and month of birth of the policyholder with the other insurer
   M M Y Y Y Y

Section C — Type of request

☐ Initial request (complete sections D-F-G)
☐ Request for change of treatment (complete sections D-F-G)
☐ Request for renewal of authorization (complete sections E-F-G)

Section D — Initial request or change of treatment — Clinical information relating to the drug

Important : Please use a different form for each drug requested.

1. Name of the drug requested for evaluation ______
2. Dosage ______ 3. Weight ______ Height ______
4. Pharmaceutical form ______ 5. Strength ______
6. Expected duration of the treatment From Y Y Y Y M M D D until Y Y Y Y M M D D
7. Diagnosis and therapeutic indication for which the drug is prescribed.

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Section D — Initial request or change of treatment - Clinical information relating to the drug (continued)

8. Please indicate all previous drug trials. Provide details of the treatment(s) duration 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 Y Y Y Y M M D D to Y Y Y Y M M D D	from Y Y Y Y M M D D to Y Y Y Y M M D D	from Y Y Y Y M M D D to Y Y Y Y M M D D

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

Section E — Request for renewal of authorisation — Clinical information

1. Specify the beneficial effects of this drug since the beginning of the treatment.

Section F — Patient support program (PSP)

Renewal with UV Insurance ☐

Important : Complete this section if this is an initial request or a change of insurer.

1. Please indicate if the patient is enrolled in a patient support program (PSP) ☐ Yes ☐ No

If so, please provide the following information:

a) Name of the program (PSP) ______

b) First name of the contact person ______ Last Name ______

c) Program ID nº ______

d) Telephone ( ) - **e)** Fax ( ) -

Note: Please note that for certain drugs, enrollment in a patient support program may be required in order for UV Insurance to accept the reimbursement of the requested drug.

Section G — Signature

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

X ______ Y Y Y Y M M D D

Signature of the authorised prescriber

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ▪ Phone: 819 478-1315 ▪ Toll free: 1 800 567-0988 ▪ Fax: 819 474-1990

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