THE Great-West Life ASSURANCE COMPANY

# Request for Special Authorization

Certain prescription drugs call for a more detailed assessment to help ensure that they represent reasonable treatment. Special Authorization requires that you request approval from Great-West Life for coverage of certain prescription drugs.

In order for your claim to be considered, additional information from you and your physician is needed to help us determine whether:

- there are other medications that may be tried first to treat your medical condition; and
- coverage is available for the prescribed drug under other programs.

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.

Special Authorization may be limited to a specified time period and/or quantity of medication. Renewal of the Special Authorization will be considered upon request from the plan member. The renewal request should include information from the physician supporting continued use of the medication.

## Form Completion Instructions:

1. **Print this information sheet and the attached Special Authorization form;**
2. **Complete Part 1 and Part 2 of the form;**
3. **Have your physician complete Part 3 of the form;**
4. **Send the completed Request for Special Authorization form to us by mail or fax to the address or fax number noted below and at the end of the form.**

## Acknowledgements

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 this drug and for administering the group 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, any insurance or reinsurance company, administrators of government benefits or patient assistance programs 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 this drug and to administer the group 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.

## Please have Part 3 completed by your prescribing physician.

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

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

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M7282(168000)-8/15

THE Great-West Life ASSURANCE COMPANY

# Request for Special Authorization

The purpose of this form is to obtain information required to assess your drug claim. To be eligible for coverage, the drug must represent reasonable treatment of the disease or injury upon which your claim is based. Approval for coverage of this drug may be reassessed at any time at Great-West Life's discretion.

**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.**

***Please print***

| **Part 1 Plan Member Information** | |
|---|---|
| Plan Member: | Patient Name: |
| Plan Number:<br>☐ **168000** ☐ **168074** | Plan Member Identification Number: |
| Patient Date of Birth (DD/MM/YYYY): | Address (number, street, city, province, postal code): |

**Part 2 Coordination of Benefits**

Are you currently on, or have you 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 Great-West Life please provide a Pharmacy print out showing purchase of this drug).

**Have you applied for coverage or received any financial assistance or other support related to this drug:**

| | |
|---|---|
| Under any group benefit plan?<br>☐ Yes ☐ No | If Yes, name of covered family member: _____<br>Relationship: _____<br>Name of Insurance Company: _____<br>Plan number: _____ Plan Member I.D. number: _____<br>**Provide details and attach documentation of acceptance or declination:**<br>_____ |
| Under a provincial program or from any other source?<br>☐ Yes ☐ No | If Yes, name of program or other source: _____<br>**Provide details and attach documentation of acceptance or declination:**<br>_____<br>If No, please explain why application has not been made:<br>_____ |
| Under a patient assistance program?<br>☐ Yes ☐ No | If Yes, name of program(s): _____<br>Patient assistance program I.D. number: _____<br>Patient assistance program contact person name and phone number:<br>Contact name: _____ Phone number: (_____) _____ |

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

**I acknowledge/declare that the information I have provided on this form is true, correct, and complete to the best of my knowledge.**

**Patient/Guardian's signature:** _____ **Date:** _____

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***Attach extra information if necessary.***

**Part 3 Physician Information (to be completed for all conditions for which the drug has been prescribed).**
***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 requested below.***

## TO BE COMPLETED BY PHYSICIAN

| Physician Name: | Specialty: | |
|---|---|---|
| Telephone Number (including area code): | Fax Number (including area code): | Registration number: |
| Address: | | |

## DRUG REQUESTED FOR SPECIAL AUTHORIZATION

| Drug Name: | Dosage: | Duration: |
|---|---|---|
| Patient Diagnosis (include date of initial diagnosis) (MM/YYYY): | | |

| Previous Medication Trial | Dosing Regimen | Start Date (DD/MM/YYYY) | End Date (DD/MM/YYYY) | Patient response to treatment (if discontinued, provide details of intolerance, contraindication, or failure at maximum dose) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## REASON FOR REQUEST

☐ contraindication ☐ therapeutic failure ☐ adverse event

☐ Other (provide details): _____

## DIAGNOSTIC TESTING

Diagnosis confirmed via: _____ Date (MM/YYYY): _____

## OTHER COMMENTS:

**I certify that the information provided on this Part 3 is true, correct and complete.**

Physician's signature: _____ Date: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. The completed Request for Special Authorization form can be returned to Great-West Life by mail or fax.

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Drug Services
PO Box 6000
Winnipeg MB R3C 3A5

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



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