beneva

Request for authorization
Generic substitution exception

Instructions

Complete the form
1. The plan member completes Section A.
2. The prescriber completes Section B.
3. If the request is approved, the effective date is the initial date of the physician's signature.

Submit the form
1. By fax: 1 855 453-3942
2. By mail: CP 11051, succ Sainte-Foy, Québec QC G1V 0K1

Customer service
1 888 235-0606

A – Plan member's statement

1. Plan member's information

Group/Policy number | Certificate/Identification number | Email

Last name | First name

Address (No.) | Street | Apt.

City | Province | Postal code | Telephone

2. Patient information

Last name | First name | Date of birth (Y Y Y Y M M D D)

Relationship to the plan member: ☐ Plan member ☐ Spouse ☐ Dependent child

Child's status: ☐ Child with disabilities ☐ Student Educational institution: _____

3. Protection of Personal Information

Protecting your personal information is a priority for Beneva. To find out more about our practices, please consult the *Privacy statement* located at **beneva.ca**.

4. Statement

I authorize any healthcare professional and intervening party in the field of health, healthcare service provider, public or private health or social services institution, private, public or parapublic agency, insurance or reinsurance company, information agency as well as any person or entity likely to be holding personal information about me or my dependents, particularly medical records, to communicate it to Beneva Inc. when it is required for administering my group insurance contract including, in particular, assessing, verifying, processing and settling my claims. I acknowledge having obtained consent from any other people included in this request for Beneva Inc. to gather, use and communicate their personal information.

I declare that the information provided on this form is true and complete.

X _____ | Y Y Y Y M M D D

Signature | Date

Beneva inc.
C.P. 11051, succ. Sainte-Foy, Québec (Québec) G1V 0K1
1 877 841-0606

COL-F0071A (2023-06)

B – Prescriber's statement

1. Prescriber's information

Last name	First name	Telephone
Licence number	Specialty	Fax

2. Prescription drug(s) for which authorization is being requested

Prescription drug name	Reason code:
Prescription drug name	Reason code:
Prescription drug name	Reason code:

Reason code:	Therapeutic considerations justifying the use of one or more brand name drugs
NPS A	Documented allergy to a non-medicinal ingredient in generic prescription drugs that is not present in the brand name drug.
NPS B	Documented intolerance to a non-medicinal ingredient in generic prescription drugs that is not present in the brand name drug.
NPS C	The brand name drug is the only one listed on the *List of Medications* in the pharmaceutical form that is essential for attaining the desired clinical results.
Immune suppressants	A prescription for an immunosuppressor (azathioprine, mycophenolate mofetil, mycophenolate sodium, sirolimus, tacrolimus) indicating "Do Not Substitute."
Clozapine	A prescription for clozapine indicating "Do Not Substitute."

3. Statement

I certify that the information provided above is accurate.

X _____ Y Y Y Y M M D D

Signature Date

Beneva inc.
C.P. 11051, succ. Sainte-Foy, Québec (Québec) G1V 0K1
1 888 235-0606

COL-F0071A (2023-06)