beneva

Request for a prior authorization drug

☐ Initial request ☐ Renewal

Instructions

Complete the form

1. The plan member completes Section A.
2. The prescriber must complete Section B (Initial request) or C (Renewal).

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. 1 888 235-0606
2. The Client Centre's *Contact Us* section

The plan member is responsible for any fees charged for the completion of this form.

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's 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. Other prescription drug insurance held by the patient

Private plan

Is the patient covered under another private prescription drug insurance plan? ☐ Yes ☐ No

If so → Name of the insurance company: _____

Status of the application: ☐ Accepted ☐ Denied ☐ Pending ☐ The application was not submitted

Provincial plan

Is the patient covered for the requested prescription drug by a provincial plan? ☐ Yes ☐ No

If so → Status of the application: ☐ Accepted ☐ Denied ☐ Pending ☐ The application was not submitted

If the patient is covered under another prescription drug insurance plan, please attach the acceptance or denial documents, if applicable.

4. 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**.

5. Plan member's 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 _____ | Date (Y Y Y Y M M D D)

Plan member's signature

COL-F0344A (2023-09)

B – Prescriber's statement – Initial request

1. Prescriber's information

Last name | First name | Telephone

Licence number | Specialty | Fax

2. Prescribed drug

Prescription drug name | Start of treatment (Y Y Y Y M M D D) | End of treatment (Y Y Y Y M M D D)

Pharmaceutical form | Strength | Prescribed dose | Dosage frequency

Place of administration:
- ☐ At a hospital, residential and long-term care centre, public or subsidized private nursing home, during outpatient consultations
- ☐ At home, a CLSC or a private office
- ☐ Other, specify: _____

Type of administration:
- ☐ Monotherapy
- ☐ In combination, specify: _____

3. Diagnosis

Diagnosis: _____

Start of symptoms: (Y Y Y Y M M D D)

4. Relevant test results BEFORE the start of treatment

Please do not provide results of any genetic tests.

	Type of test	Results	Date
Laboratory test (e.g. hemogoblin, LDL-Chol, etc.)			(Y Y Y Y M M D D)
Recognized scales for evaluating the gravity (DLQI, HAQ, ECOG, etc.)			(Y Y Y Y M M D D)
Examinations at a clinic (imaging, investigation report, BMI)			(Y Y Y Y M M D D)

5. Additional information

6. Previous medication or treatment

Medication or treatment	Dose	Reason for stoppage	Treatment period
		☐ Ineffective ☐ Intolerance ☐ Contraindication ☐ Other: _____	Start: (Y Y Y Y M M D D) End: (Y Y Y Y M M D D)
		☐ Ineffective ☐ Intolerance ☐ Contraindication ☐ Other: _____	Start: (Y Y Y Y M M D D) End: (Y Y Y Y M M D D)
		☐ Ineffective ☐ Intolerance ☐ Contraindication ☐ Other: _____	Start: (Y Y Y Y M M D D) End: (Y Y Y Y M M D D)

7. Prescriber's statement

I declare that the information provided is true and complete. A photocopy of this authorization is considered as valid as the original.

X _____ (Y Y Y Y M M D D)

Prescriber's signature | Date

C – Prescriber's statement – Renewal

1. Prescriber's information

Last name	First name	Telephone
Licence number	Specialty	Fax

2. Prescribed drug

Prescription drug name	Start of treatment (Y Y Y Y M M D D)	End of treatment (Y Y Y Y M M D D)

Pharmaceutical form	Strength	Prescribed dose	Dosage frequency

Place of administration:
- ☐ At a hospital, residential and long-term care centre, public or subsidized private nursing home, during outpatient consultations
- ☐ At home, a CLSC or a private office
- ☐ Other, specify: _____

Type of administration:
- ☐ Monotherapy
- ☐ In combination, specify: _____

3. Diagnosis

Diagnosis: _____

Start of symptoms: Y Y Y Y M M D D

4. Clinical information related to continuing treatment

Please do not provide results of any genetic tests.

	Type of test	**Result of initial evaluation**	**Result of the most recent subsequent evaluation**
Laboratory test (e.g. hemogoblin, LDL-Chol, etc.)		Date: Y Y Y Y M M D D	Date: Y Y Y Y M M D D
Recognized scales for evaluating the gravity (DLQI, HAQ, ECOG, etc.)		Date: Y Y Y Y M M D D	Date: Y Y Y Y M M D D
Examinations at a clinic (imaging, investigation report, BMI)		Date: Y Y Y Y M M D D	Date: Y Y Y Y M M D D

5. Additional information

6. Prescriber's statement

I declare that the information provided is true and complete. A photocopy of this authorization is considered as valid as the original.

X _____ Y Y Y Y M M D D

Prescriber's signature — Date