Drug Dosage Increase for a previously approved Prior Authorization Drug

This form is intended to obtain information required to review a drug dose that is not within Health Canada's recommended guidelines.

IMPORTANT: Please answer all questions. Your claim assessment may 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.

Part 1 Plan Member Information (please print)		
Plan Member:	Patient Name:	
Plan Name:	Plan Number:	Plan Member ID Number:
Patient Date of Birth (DD/MM/YYYY):	Address (number, street, city, province, postal code):	
Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient.		
May we contact you by email? (Note that some correspondence may still need to be sent by regular mail). ☐ Yes ☐ No If yes, please provide email address: ______		

Canada Life recognizes and respects the importance of privacy. Personal information collected 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 Canada Life's personal information policies and practices (including with respect to service providers), refer to www.canadalife.com or write to Canada Life's Chief Compliance Office.

I authorize Canada 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 Canada 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 consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

Plan Member's signature: ______________________ Date: ______________________

M7268-1/20

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

Physician's Questionnaire

Please have Part 2 completed by your prescribing physician.

Part 2 Physician's Information (please print)

Name of prescribing physician (please print):	
Specialty:	
Address (number, street, city, province, postal code):	
Telephone Number (including area code):	Fax Number (including area code):
Prior Authorization Drug: ______	Medical Condition: ______

1. Provide the date this drug was first started (DD/MM/YYYY): ______
2. Provide the starting dose and frequency for this drug: ______
3. Patient's current weight: ______ kg Date Determined (DD/MM/YYYY) ______
4. Dose and/or frequency requested: ______
5. Medical rationale for the dose and/or frequency increase:

   ______

   ______

   Please provide supporting lab results and/or investigative reports

   (Genetic test results are not required)

6. Has therapeutic drug monitoring (TDM) testing been performed? ☐ Yes ☐ No ☐ Not applicable

   Please submit lab results

   If no, provide rationale: ______

7. Is there evidence supporting the effectiveness and safety for the requested drug's dose and/or frequency?

   ☐ Yes ☐ No ☐ Not applicable

   Provide clinical literature/studies to support the request, such as:

   - At least two Phase II or two Phase III clinical trials showing consistent results of efficacy
   - Published evidence-based guideline recommendations

   Attach supporting documentation

I certify that the information provided is true, correct, and complete.

Physician's signature: ______ Date: ______

License Number: ______

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 Information form can be returned to Canada Life by mail, fax or email.

Note: As email is not a secure medium, any person with concerns about their medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to: **The Canada Life Assurance Company**
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: **The Canada Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to: **cldrug.services@canadalife.com**
Attention: Drug Claims Management