Drug Exception Request Form

Use this form to request coverage of a *drug that is* **not** *automatically covered* under your drug plan. **Provide the requested information to ensure timely assessment of your claim.**

PLAN MEMBER INFORMATION

Policy Number: 161332	Student Name:
Student ID #:	Address

PATIENT INFORMATION

Patient:	Relationship:	Date of Birth:

I hereby authorize The Canada Life Assurance Company to use the information provided herein and/or consult with the below stated physician to determine eligibility for special authorization drug benefits.

Student/Patient's signature: _____ Date: _____

BRITISH COLUMBIA, SASKATCHEWAN OR MANITOBA residents:

If you are a resident of British Columbia, Saskatchewan or Manitoba and the requested drug has been approved by the Provincial Drug Program on an exception basis, please send us a copy of the government approval letter. (If this section applies to you, then you do not need to complete the remainder of this form.) Coverage will be added to your Pay Direct Drug Card (myBenefits Card) within 2 -3 days.

PLEASE HAVE THE FOLLOWING COMPLETED BY YOUR PHYSICIAN:

Physician's Name:	Registration Number:
Address:	
Telephone Number:	Fax Number

REQUIRED INFORMATION

In order to be considered for a drug exception, you must have tried at least one medication on your plan's applicable formulary.

Diagnosis:

Drug prescribed and DIN #, if known:

Alternative treatments attempted (Please provide specific drug names and din #'s, if known. Please note this request will not be considered if this section is not completed).

If no other medication was tried, please explain why this drug must be prescribed (for example a contraindication resulting from an allergy reaction).

Information on requested drug

Drug Name:	Dose prescribed:
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. This form may be subject to audit. The completed 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 prior authorization form/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

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

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

M6586A-1/20

Clear