Drug exception application form

Sun Life Financial

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping information concerning this application confidential.

1 Important – please read carefully

Sometimes it may be medically necessary for your physician to prescribe a drug that is not covered, not fully covered or that requires more frequent dispensing than is currently eligible under your plan. If this is your situation, you can request that Sun Life Assurance Company of Canada make an exception.

Exceptions will only be made for drugs which legally require a prescription.

To be eligible for coverage, trials with two alternative drugs covered on your plan may be required.

If you have already purchased the medication for which you are requesting an exception, please attach all original receipts along with a regular extended health care claim form.

Your exception request will be reviewed and a decision will be communicated to you in writing and will include the period for which this decision applies.

Please note that the completion of this form is not a guarantee of approval. It must be completed in full, otherwise it will be returned to you. Any expense for medical evidence to support this request is your responsibility.

2 To be completed by Plan Member

Please have your physician complete the reverse side of this form.

Plan Member information

Contract number	Member ID number	Your plan sponsor/employer		
Your last name	First name	☐ Male ☐ Female	Date of birth (yyyy-mm-dd)	
Your address (street number and name)			Apartment or suite	
City	Province	Postal code		
Preferred language of correspondence ☐ English ☐ French	Daytime telephone number			

Claimant information

Claimant's last name	Claimant's first name
Date of birth (yyyy-mm-dd)	Relationship to Plan Member ☐ Self ☐ Spouse ☐ Child

Reason for request (choose one)

- ☐ Request for the full cost of the drug to be eligible under my plan: claimant is unable to take the lower priced equivalent drug.
- ☐ Request for the highest coinsurance available under my plan: claimant is unable to take an alternate drug available under a higher coinsurance.
- ☐ Request to be covered for a drug not covered under my plan.
- ☐ Request for additional dispensing fee to be covered under my plan.

Authorization and signature

I certify that the information I provided above is true and complete.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this application including health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Plan Member's signature	Date (yyyy-mm-dd)
X	

3 To be completed by prescribing physician

Condition and treatment

Diagnosis
Describe relevant medical condition

Drug exceptions requested

Drug name		
DIN	Is this drug exception a ☐ new request? or a ☐ renewal request?	
Treatment effective date (yyyy-mm-dd)	Anticipated duration of therapy	Dosage
Medical reason for requesting drug exception: ☐ Contraindication ☐ Severe adverse reaction ☐ Therapeutic failure ☐ Drug interaction ☐ Other (please specify)		
Describe the nature, extent and severity of the above reason		
How is the drug being monitored for effectiveness and safe use?		
Are you aware if other physicians or practitioners are treating this patient and prescribing medication for the same condition?		
List other drugs patient has used/is using for this medical condition. 1. Drug name		DIN
2. Drug name		DIN
Comments		
Physician's last name	First name	Telephone number
Physician's address (street number and name)		
City	Province	Postal code
Physician's signature X		Date (yyyy-mm-dd)

3 To be completed by prescribing physician (continued)

Dispensing fee frequency exceptions requested

Drug name		
DIN	Is this drug exception a ☐ new request? or a ☐ renewal request?	
Treatment effective date (yyyy-mm-dd)		
Medical reason for requesting dispensing fee frequency exception: ☐ Patient safety ☐ Treatment monitoring ☐ Other (please specify)		
Physician's last name	First name	Telephone number
Physician's address (street number and name)		
City	Province	Postal code
Physician's signature X		Date (yyyy-mm-dd)

Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Questions? Please visit **www.sunlife.ca** or call toll-free 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

Mailing instructions – keep a copy for your records

Mail or fax your completed form to the claims office nearest you.

Fax number: 1-855-342-9915

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