CINUP

# AUTHORIZATION REQUEST FOR BRAND NAME DRUG COVERAGE

JG101

The information provided here helps us assess your request for coverage of a non-generic drug. To be eligible for this coverage, medical evidence must show you will experience adverse side effects from use of a generic version.

You are responsible for any fees your doctor may charge to complete this form.

## PATIENT IDENTIFICATION

Patient's Name _____

Employee's Name _____ Phone (____) _____

Firm/Division # _____ Certificate # _____

Address _____
Number, Street City Province Postal Code

## PHYSICIAN IDENTIFICATION (TO BE COMPLETED BY PHYSICIAN. PLEASE PRINT.)

Physician's Name _____
Last Name First Name

Address _____
Number, Street City Province Postal Code

Specialty _____ Phone (____) _____

## IDENTIFICATION OF REQUESTED DRUG (TO BE COMPLETED BY PHYSICIAN. PLEASE PRINT.)

Brand name requested _____ DIN _____ Dosage/frequency _____

Generic drug prescribed _____ DIN _____ Dosage/frequency _____

☐ The patient has exhausted all available avenues for coverage, including applicable drug manufacturer patient support and financial assistance programs (e.g., InnoviCares).

Outcome attributed to generic medication (Please specify the nature, extent, and severity of the reaction where applicable, or indicate 'N/A'):

Adverse reaction _____

Therapeutic failure _____

Allergic reaction _____

Other _____

Anticipated duration of therapy _____

Signature of Physician _____ Date _____

## DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the form is accurate and complete, to the best of my knowledge.

I authorize CINUP and its insurers to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the *Privacy & Terms of Use* section of cinup.ca or from the administrator of my benefit program.

Signature of Employee _____ Date _____