beneva

Request for generic substitution exception

Instructions

Complete the form

1. The plan member completes Section A.
2. The prescriber completes Section B.
3. If the request is approved, the effective date is the initial date of the physician's signature.

Submit the form

1. By fax: 1 855 453-3942
2. By mail: CP 11051, succ Sainte-Foy, Quebec QC G1V 0K1

Customer Service

1 888 235-0606

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. 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* at beneva.ca.

4. Declaration

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)

Signature

B – Prescriber's statement

Lack of efficacy of generic versions does not justify reimbursement of a brand name drug.

Failure to answer any question on the form will result in a denial since the authorization criteria cannot be validated.

1. Prescriber's information

Last name	First name	Telephone
Licence number	Specialty	Fax

2. Brand name drug requested

Prescription drug name

Pharmaceutical form	Strength	Prescribed dose	Dosage frequency:

3. Request information

1. Brand name of the generic drug responsible for the allergy or severe intolerance	Name: _____ Form: _____ Strength: _____
2. Observed reaction	☐ Intolerance ☐ Allergy (proceed directly to question 4) *Any other justification will be denied.
3. Consequence of the intolerance for the individual	☐ Hospitalization ☐ Prolonged hospitalization ☐ Emergency medical intervention ☐ Persistent or significant disability or incapacity ☐ Other, specify: _____
4. Detailed description of the reaction, its consequences, and the measures taken to treat it	

3. Request information (cont.)

5. Date of the event or onset of the reaction	
6. Name of the **non-medicinal** ingredient that caused the reaction (this information is required to answer the following questions)	
7. Is the non-medicinal ingredient that caused the reaction present in the brand-name drug?	☐ Yes ☐ No

8. Is a generic drug with the same composition as the requested brand-name drug available in Canada?

☐ Yes. Drug name: _____

☐ No

9. Is a generic drug that does not contain the non-medicinal ingredient causing the reaction available in Canada?

☐ Yes. Drug name: _____

☐ No

If the brand-name drug is not the only version of the medication available in Canada without the ingredient causing the reaction, your request will be denied.

10. Other common names that have been tried to avoid the allergy or severe intolerance	

4. Additional information

5. Declaration

I certify that the information provided above is accurate.

X _____ Y Y Y Y M M D D

Signature Date

Beneva inc.
C.P. 11051 succ. Sainte-Foy, Quebec QC G1V 0K1
1 888 235-0606

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