beneva

Request for authorization
Mandatory transition
to biosimilars exception

Instructions

Complete the form
1. The plan member completes Section A.
2. The prescriber completes Section B.

Submit the form
1. By fax: 1 855 453-3942
2. By mail: CP 11051, succ Sainte-Foy, Québec 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 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. Other prescription drug insurance held by the patient

Private plan Is the patient covered under another private prescription drug insurance plan? ☐ Yes ☐ No

If so → Name of the insurance company: _____

Status of the claim: ☐ Accepted ☐ Denied ☐ Pending ☐ The application was not submitted

Public plan Is the patient covered for the requested prescription drug by a public plan? ☐ Yes ☐ No

If so → Status of the application: ☐ Accepted ☐ Denied ☐ Pending ☐ The application was not submitted

If the patient is covered under another prescription drug insurance plan, please attach the acceptance or denial documents, if applicable.

4. 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* located at **beneva.ca**.

5. Statement

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

Beneva inc.
C.P. 11051, succ. Sainte-Foy, Québec (Québec) G1V 0K1
1 888 235-0606

COL-F0072A (2024-02)

B – Prescriber's statement

1. Prescriber's information

Last name	First name	Telephone
Licence number	Specialty	Fax

2. Prescribed drug

Prescription drug name	Start of treatment (Y Y Y Y M M D D)	End of treatment (Y Y Y Y M M D D)

Pharmaceutical form	Strength	Prescribed dose	Dosage frequency

3. Exceptions to the mandatory transition

☐ Pregnant Expected delivery date: Y Y Y Y M M D D

☐ Persons under 18 years of age

☐ The requested drug is administered with an insulin pump that is not compatible with the equivalent biosimilar version, specify:

☐ Eligible person undergoing treatment with this drug is monocular

☐ Therapeutic failure with at least two other biologic drugs before beginning treatment with the reference biologic drug, specify:

Biologic drug	Usage date
	Start: Y Y Y Y M M D D End: Y Y Y Y M M D D
	Start: Y Y Y Y M M D D End: Y Y Y Y M M D D
	Start: Y Y Y Y M M D D End: Y Y Y Y M M D D

☐ Other reason, specify:

4. Prescriber's statement

I certify that the information provided above is accurate.

X _____ Y Y Y Y M M D D

Signature Date

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