beneva

Request for assessment
Exception patient measure

☐ **Initial request** ☐ **Renewal**

Instructions

Complete the form
1. The plan member completes Section A.
2. The prescriber must complete Section B (Initial request) or C (Renewal).

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. 1 888 235-0606
2. The Client Centre's *Contact Us* section

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? ☐ No ☐ Yes

If so → Name of the insurance company: _____

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

Provincial plan Is the patient covered for the requested prescription drug by a provincial plan? ☐ No ☐ Yes

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 very important to Beneva. To find out more about our procedures, please read our *Privacy Statement* at beneva.ca.

5. Plan member's 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)

Plan member's signature

COL-F0081A (2023-07)

B – Prescriber's statement – Initial request

1. Prescriber's information

Last name	First name	Telephone
Licence number	Specialty	Fax

2. Drug prescribed

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

Location administered:
- ☐ At a hospital, residential and long-term care centre, public or subsidized private nursing home, during outpatient consultations
- ☐ At home, a CLSC or a private office
- ☐ Other, specify: _____

3. Diagnosis

Diagnosis: _____ Start of symptoms: Y Y Y Y M M D D

4. Results of analysis

Relevant test results before the start of treatment. Please do not provide results of any genetic tests.

	Type of test	Results	Date
Laboratory test (e.g. Hb, LDL-Chol, etc.)			Y Y Y Y M M D D
Recognized scale for evaluating the gravity (DLQI, HAQ, ECOG, etc.)			Y Y Y Y M M D D
Examinations at a clinic (MRI, investigation report, BMI)			Y Y Y Y M M D D

5. Functional consequences

Functional consequences before beginning treatment

Does the condition have observable physical or psychological functional consequences on the patient's usual activities? ☐ No ☐ Yes

If so → Specify the type of activity and extent of limitation.

Physical activities (walking, climbing stairs, lifting objects or other activities)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Daily activities at home (personal hygiene, meal preparation, housework or other)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Daily activities outside the home (job, school, shopping, recreation or other)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Social activities (dining in a restaurant, seeing a movie, visiting family, volunteer work or other)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

* 0 = no limitation 1 = mild limitation 2 = moderate limitation 3 = severe limitation 4 = extreme limitation

6. Previous medication or treatment

Medication or treatment	Dose	Reason for stoppage	Treatment period
		☐ Ineffective ☐ Intolerance, specify: ☐ Contraindication, specify:	Start: Y Y Y Y M M D D End: Y Y Y Y M M D D
		☐ Ineffective ☐ Intolerance, specify: ☐ Contraindication, specify:	Start: Y Y Y Y M M D D End: Y Y Y Y M M D D
		☐ Ineffective ☐ Intolerance, specify: ☐ Contraindication, specify:	Start: Y Y Y Y M M D D End: Y Y Y Y M M D D
		☐ Ineffective ☐ Intolerance, specify: ☐ Contraindication, specify:	Start: Y Y Y Y M M D D End: Y Y Y Y M M D D

7. Additional information

Describe any other medications or medical treatments that are recognized as being effective for treating this condition that cannot be prescribed due to the specific clinical conditions of this case:

8. Statement

I certify that the information provided above is accurate.

X _____ Y Y Y Y M M D D

Prescriber's signature Date

COL-F0081A (2023-07)

C – Prescriber's statement – Renewal

1. Prescriber's information

Last name | First name | Telephone

Licence number | Specialty | Fax

2. Drug prescribed

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

Location administered:
- ☐ At a hospital, residential and long-term care centre, public or subsidized private nursing home, during outpatient consultations
- ☐ At home, a CLSC or a private office
- ☐ Other, specify: _____

3. Diagnosis

Diagnosis: _____ Start of symptoms: (Y Y Y Y M M D D)

4. Patient clinical information

Clinical information about continuing treatment. Please do not provide results of any genetic tests.

	Type of test	**Result of initial evaluation**	**Result of the most recent evaluation**
Laboratory test (ex. : Hb, LDL-Chol, etc.)		(Y Y Y Y M M D D)	(Y Y Y Y M M D D)
Recognized scale for evaluating the gravity (DLQI, HAQ, ECOG, etc.)		(Y Y Y Y M M D D)	(Y Y Y Y M M D D)
Examinations at a clinic (MRI, investigation report, BMI)		(Y Y Y Y M M D D)	(Y Y Y Y M M D D)

5. Other beneficial effects observed since beginning treatment

6. Additional information

7. Prescriber's statement

I certify that the information provided above is accurate.

X _____ (Y Y Y Y M M D D)

Prescriber's signature | Date

COL-F0081A (2023-07)