Assumption Life
Group Insurance

Reset

Special Authorization Request

Section 1 To be Completed by Employee

PLEASE SUBMIT A COPY OF PHARMACY MEDICATION HISTORY OF PATIENT FOR THE PREVIOUS 12 MONTHS.

Employee's first name | Employee's last name | Policy | Division | Certificate

Address | City | Province | Postal Code

E-mail | Telephone

Patient's first name | Patient's last name

Relationship to Employee: ☐ Employee ☐ Spouse ☐ Child

Patients Date of Birth: (DD/MM/YYYY) ___ / ___ / _____

I hereby authorize any physician, hospital, insurance company, other healthcare professional and Assumption Life to exchange information in regard to this claim for the purpose of special authorization/patient exception evaluation, adjudication of claims, and administration of my health benefit program. I assume responsibility for any fees associated with the completion of this form. A photocopy of this authorization shall be as valid as the original.

Signature of Patient (parent or legal guardian if patient is a minor dependent) | Date (DD/MM/YYYY)

Section 2 To be Completed by Physician (please print clearly)

Name of Physician | Specialty Qualification | Telephone | Fax

Address of Physician | City | Province | Postal Code

Signature of Physician | Date (DD/MM/YYYY)

Drug for Which Special Authorization is Requested (one form per drug)

Drug Name | Strength | Dosage

Diagnosis | Treatment (duration)

Previous Drugs Prescribed for This Condition (if applicable)

Drug Name | Strength | Dosage

Reason for discontinuation | Treatment (duration)

Drug Name | Strength | Dosage

Reason for discontinuation | Treatment (duration)

Reason for prescribing requested drug:

☐ No other therapeutic alternative for patient's medical condition
☐ Could not tolerate prior treatment / side effects
☐ Prior treatment used was ineffective
☐ Other

Please provide explanation below, or on the back of this form, to expand on checked item(s). Attach supporting documentation where applicable.

Relevant medical information (if applicable):

☐ HAQ Disability Index _____ ☐ EDSS Rating _____ ☐ WHO functional Class II _____
☐ Viral Genotype_____ ☐ BASDAI/BASFI Score_____ ☐ ECOG Performance Status _____
Lab results _____

Site of Drug Administration (if applicable):

☐ Home ☐ Doctor's Office ☐ Private Clinic ☐ Hospital Clinic ☐ Hospital ☐ LTC Facility

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 1-855-401-9068 E-mail: group@assumption.ca