Sun Life

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Prior Authorization Request

Instructions

Please complete Part A and have your physician complete Part B. This form may not apply to your specific plan. Before completing the Prior Authorization form, check that this medication is on your plan's drug coverage list. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. If you've already purchased the drug, please attach your original receipts along with a regular extended health care claim form.

Part A – Patient

Patient Information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Please check any box that applies to the patient:

☐ The patient is an over-age student dependent (i.e. attending University or College full-time). A copy of the enrolment document from the educational institution confirming full-time status is enclosed.

☐ The patient is a spouse or a dependent over age 18. The patient has signed the authorization section below that allows Sun Life to obtain the additional medical information pertaining to this request.

Coordination of benefits

Provincial Coverage	You applied for a drug that may be covered under a provincial plan. To find out if you qualify for coverage, speak to your doctor and apply to the province. Show the provincial response letter to your pharmacist when you receive it.
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

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Authorization

The answers on this form are true. I allow Sun Life to collect, use and disclose my personal information for three reasons. These reasons are plan administration, underwriting coverage and assessing claims. Sun Life may share (meaning collect and disclose) information with healthcare providers, hospitals, clinics, pharmacies, government programs, patient assistance programs, and any other organization with relevant information about me. Sun Life may also share information with insurers or reinsurers, and agents and service providers of Sun Life and the above parties. Sun Life will share my information only when necessary. My consent applies while this plan is in effect.
I agree that a photocopy or electronic version of this authorization is as valid as the original.

Plan Member Signature _____ Date _____

Patient Signature (if over 18 years of age) _____ Date _____

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

Drug Name ☐ New request ☐ Renewal request*				
DIN(s)	Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Private Clinic ☐ Private Clinic (within Hospital - no public or government funding)

☐ Hospital (inpatient) ☐ Hospital (outpatient)

Name of the hospital or private clinic:		
Address:		
City:	Province:	Postal code:

* Please submit proof of prior coverage if available

Please select reason for this request (choose one):

Sometimes it may be medically necessary to prescribe a drug that is not covered, not fully covered or that requires more frequent dispensing than is currently eligible under the patient's plan. If this is the situation, the patient may request an exception from Sun Life by completing this form. Drug exceptions for prescription drugs are only considered if the drug is being used for a medical condition that is an approved indication according to Health Canada.

☐ If the patient is unable to take the lower priced equivalent drug and you're requesting the full cost of the drug to be eligible under their plan, please complete Part A.

☐ If the patient is unable to take an alternate drug available at a higher reimbursement level and you're requesting the highest reimbursement level under the patient's plan, please complete Part B.

☐ If you're requesting the additional dispensing fee to be covered, please complete Part C.

☐ If you're requesting coverage for a drug not covered under the patient's plan, please complete Part D.

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SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Part A: Patient is unable to take the lower priced equivalent drug

Medical reason for requesting drug exception

- ☐ Contraindication to the lower priced equivalent drug
- ☐ Severe adverse reaction to the lower priced equivalent drug
- ☐ Therapeutic failure of the lower priced equivalent drug
- ☐ The lower priced equivalent drug has drug-drug interactions with other drugs patient is on
- ☐ Other (please specify): _____

Describe the nature, extent and severity of the above reason. If drug-drug interaction, please identify the other drugs and nature of the interaction.

Part B: Patient is unable to take alternative drug(s) available under a higher reimbursement level

For the requested drug to be eligible for coverage, trials with two alternative drugs covered by the patient's plan may be required. List other drugs the patient has used, is using or cannot use for this medical condition:

Drug & dose	Dates of therapy, if applicable	List medical reason(s) for not using	Describe nature and severity of reason
		☐ contraindication ☐ severe adverse drug reaction ☐ therapeutic failure ☐ drug-drug interaction ☐ other: _____	
		☐ contraindication ☐ severe adverse drug reaction ☐ therapeutic failure ☐ drug-drug interaction ☐ other: _____	

Part C: Additional dispensing fee to be covered

Medical reason for requesting dispensing fee frequency exception:

- ☐ Patient safety
- ☐ Treatment monitoring
- ☐ Other (please specify): _____

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Part D: Coverage for a drug not covered under claimant/patient's plan

INITIAL

Please provide the following information. Do not provide any genetic test results.

☐ Date of diagnosis: _____

☐ Clinical details regarding patient's current condition including symptoms, signs, and prognosis

☐ Details of previous treatments (including drug name, dose, dates of treatments and reasons for discontinuation) or details of contraindications to alternate treatments

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

☐ What are the goals of therapy with requested drug and how are the goals monitored?

☐ If the patient received the requested drug in the past, please provide details including dose, dates of treatments, objective evidence of benefit and reasons for stopping treatment

RENEWAL

☐ There is documented evidence of clinical benefit. Describe how treatment goals identified in the initial request have been met

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SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

SECTION 4 – RESPECTING YOUR PRIVACY

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at www.sunlife.ca/privacy or call us for a copy.

Questions? Please visit *www.sunlife.ca* or call toll-free 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

SECTION 5 – CONTACT US

You can submit **all** pages of this form through the mysunlife mobile app or mysunlife.ca. Please use 'prior auth' as the reference number.

OR

Please fax or mail the completed form to Sun Life Assurance Company of Canada ®

FAX: 1-855-342-9915

Mail:
Sun Life Assurance Company of Canada
Attention: Claims Dept.
PO Box 11658 STN CV
Montreal, QC H3C 6C1

Sun Life Assurance Company of Canada
Attention: Claims Dept.
PO Box 2010 STN Waterloo
Waterloo, ON N2J 0A6