Manulife Financial

For your future™

Group Benefits
Drug Prior Authorization

Please select the drug name:

The purpose of this form is to obtain the medical information required to assess your request for a drug on the Prior Authorization list under your drug plan benefit coverage. Please ensure this form is filled in completely or it will delay the processing of your request. Completion of this form is not a guarantee of approval. If you have already purchased the drug, please attach all original receipts along with an Extended Health Care Claim form. All costs incurred to complete this form are the plan member's responsibility.
If you are registered for the Plan Member Secure Site and have provided an email address, you will receive an email notification when the prior authorization decision is available on your claims statement. If you are not registered on the Plan Member Secure Site, you will be notified of the prior authorization decision by mail.

1 Plan member and patient information

To be completed by plan member

Plan contract number	**Plan member certificate number**	Plan sponsor

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)	Gender ◯ Male ◯ Female

Plan member address (number, street and apt.)	City or town	Province	Postal code

Phone number	Email address (optional)

Patient name (first, middle initial, last)	Patient date of birth (dd/mmm/yyyy)	Relationship to plan member

2 Provincial Plans

To be completed by plan member

Most provinces offer some form of drug coverage to their residents. Your Manulife drug plan supplements the coverage provided by provincial plans. It is important that you or your doctor (if required) apply to the applicable provincial program to ensure there are no delays in your drug reimbursement.
Login to the **Manulife Provincial Drug Plans Resource Centre** on our Plan Member Secure Site at to confirm if the drug you have been prescribed may be eligible for coverage under a provincial plan. If the drug you have been prescribed *is* listed under a provincial program, you will need to apply to the program before consideration can be given under your Manulife drug plan.

Have you applied to the provincial program for coverage? ◯ Yes ◯ No

Have you been approved for coverage by the provincial program for this drug? ◯ Yes ◯ No

Drug strength and dosage

Where will the treatment be administered?

◯ Home ◯ MD Office ◯ Private Clinic ◯ Hospital/In-patient ◯ Hospital/Out-patient

Please select the diagnosis for which the drug has been prescribed and respond to the corresponding questions.

To be completed by prescribing physician

If no previous therapies have been tried for the selected diagnosis, please specify the rationale:

◯ Risk of drug interaction ◯ Patient has contraindication

◯ Other

For the selected diagnosis, please provide all previous and current drug therapies in the area below.

Drug name	Please specify the outcome:
	◯ Intolerance (Allergy/Adverse Event) ◯ Inadequate/Suboptimal Response

Will the patient be continuing on this medication in addition to new therapy? ◯ Yes ◯ No

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	◯ Intolerance (Allergy/Adverse Event) ◯ Inadequate/Suboptimal Response

Will the patient be continuing on this medication in addition to new therapy? ◯ Yes ◯ No

Prescribing physician's name		Telephone number	Extension

Address (number, street and suite)	City or town	Province	Postal code

Physician authorization

I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits health file with Manulife Financial and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Physician's signature	Date signed (dd/mmm/yyyy)

To be signed by plan member

I certify that I, my spouse and/or my dependants of minor or major age (“Dependants”), require the prescription drug identified and that the information provided for this request is true and complete. I authorize Manulife Financial (“Manulife”) to collect, use, maintain and disclose personal information relevant to this request (“Information”) for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this request (“Purposes”). I am authorized by my Dependants to disclose and receive their Information, for the Purposes. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. I authorize the use of my Social Insurance Number (“SIN”) for the purposes of identification and administration, if my SIN is used as my plan member certificate number. I agree a photocopy or electronic version of this authorization is valid. I understand that Manulife’s Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Plan member's signature	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

Please mail or fax your completed form to the appropriate address.

If you live in Quebec:

Manulife Financial Group Benefits
Health Claims
Attention Prior Authorization Team
PO BOX 2580, STATION B
MONTREAL QC H3B 5C6

Fax: 1-855-752-0404

If you live outside Quebec:

Manulife Financial Group Benefits
Health Claims
Attention Prior Authorization Team
PO BOX 1653
WATERLOO ON N2J 4W1

Fax: 1-855-752-0404

Please retain a photocopy for your files.