

Important: All 4 pages must be completed for the application to be processed. The physician's signature is required.

Section A—Collecte, utilisation et communication des renseignements personnels

By signing this form, you authorize UV Insurance to collect, use and disclose your personal information to assess this request.

This personal information is used to:

- ▶ Confirm your identity;
- ▶ Obtain additional information required to complete the review of your request;
- ▶ Contact the relevant healthcare professionals (including your pharmacists, treating physicians, nurses, pharmacy technical assistants and dietitians), healthcare facilities, insurance companies, government authorities, government programs and patient support programs;
- ▶ Comply with legal and regulatory requirements, in particular to prevent, detect or prosecute offences, cyber threats and fraud.

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing the claim, as well as to any other person authorized by law.

Section B—Member Identification (contractholder)

1. Certificate # _____ Group # _____
2. First name _____ Last name _____
3. Date of birth

Y	M	D

Section C—Patient Identification

1. First name _____ Last name _____
2. Date of birth

Y	M	D
3. Address _____ App. # _____
City _____ Province _____ Postal code _____
4. Telephone

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5. Work

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 Ext. _____
6. Email _____
7. Relationship to member (contractholder) ☐ Member ☐ Spouse ☐ Dependent child
8. Name of drug _____
9. Name of physician _____

Section D—Other Insurance Medication Coverage

Provincial Plan

Are you covered by a provincial plan (e.g., RAMQ)? ☐ Yes ☐ No

- ▶ If **Yes**: Please send us a copy of the form submitted to the other insurer, along with a copy of the approval or denial.

Private Plan

Do you have prescription drug coverage with another private insurer (other than UV Insurance)? ☐ Yes ☐ No

- ▶ If **Yes**: Please send us a copy of the form submitted to the other insurer, along with a copy of the approval or denial.

Name of the private insurer _____

Relationship between the member and the holder of the other insurance policy ☐ Member ☐ Spouse ☐ Dependent child

If the member is a dependent, please provide the date of birth of the contractholder under the other insurer's plan.

Date

Y	M	D

Section E—Healthcare Professional Identification and Declaration

To be completed by the healthcare professional

1. First name _____ Last name _____
2. License # _____
3. Address _____
City _____ Province _____ Postal code _____
4. Telephone []-[]-[]-[]-[]-[] Ext. _____ 6. Fax []-[]-[]-[]-[]-[]

Type of Request

- ☐ Initial request ☐ Change of treatment request ☐ Renewal request

Drug Requested

1. Drug name _____ 2. Form _____ 3. Potency _____
4. Dosage _____
5. Insured person's weight _____ 6. Insured person's height _____
7. Expected treatment duration from [] Y [] M [] D to [] Y [] M [] D

- ▶ **Please complete all sections to avoid delaying the processing of your request. Please note that the form will be returned to you if any information is missing.**
- ▶ The application must be accompanied by high-quality clinical studies or other documentation justifying the use of the drug for the requested indication.
- ▶ Please send us the information required to process your request (e.g., scores, test results, lab values, imaging report, severity of the condition).

Diagnosis**Justification of the Request****Note:** For certain drugs, enrollment in a patient support program may be required in order for the reimbursement of the requested drug.**Patient Support Program (PSP)**

1. Is the patient enrolled in a patient support program? ☐ Yes ☐ No If **Yes**, please answer the following questions.
2. Name of the program _____ 3. Name of the resource person _____
4. Telephone []-[]-[]-[]-[]-[] Ext. _____ 5. Fax []-[]-[]-[]-[]-[]

Section E—Healthcare Professional Identification and Declaration (cont.)

Summary of Previous Trials

1. Please indicate all previous drug trials. Provide the duration of treatment(s) as well as the reason for their termination.

	Drug 1	Drug 2	Drug 3																																				
Name																																							
Dosage																																							
Reason	☐ Ineffectiveness ☐ Contraindication ☐ Intolerance ☐ Other, specify _____	☐ Ineffectiveness ☐ Contraindication ☐ Intolerance ☐ Other, specify _____	☐ Ineffectiveness ☐ Contraindication ☐ Intolerance ☐ Other, specify _____																																				
Duration	from <table border="0"> <tr> <td>Y</td><td>M</td><td>D</td> </tr> <tr> <td> </td><td> </td><td> </td> </tr> </table> to <table border="0"> <tr> <td>Y</td><td>M</td><td>D</td> </tr> <tr> <td> </td><td> </td><td> </td> </tr> </table>	Y	M	D				Y	M	D				from <table border="0"> <tr> <td>Y</td><td>M</td><td>D</td> </tr> <tr> <td> </td><td> </td><td> </td> </tr> </table> to <table border="0"> <tr> <td>Y</td><td>M</td><td>D</td> </tr> <tr> <td> </td><td> </td><td> </td> </tr> </table>	Y	M	D				Y	M	D				from <table border="0"> <tr> <td>Y</td><td>M</td><td>D</td> </tr> <tr> <td> </td><td> </td><td> </td> </tr> </table> to <table border="0"> <tr> <td>Y</td><td>M</td><td>D</td> </tr> <tr> <td> </td><td> </td><td> </td> </tr> </table>	Y	M	D				Y	M	D			
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2. Please indicate any additional information relevant to the evaluation of this request.

Section F—Renewal of Payment Authorization Request

To be completed by the healthcare professional

1. Name of drug _____
2. Dosage _____
3. Please provide details of any clinical benefits observed following treatment.

4. Please provide the information needed to evaluate the response to treatment, including imaging reports, assessment scale results (scores), laboratory values, clinical response, or any other relevant information.

I consent to the third parties listed above in Section A providing UV Insurance with the information required to review my request, including my medication profile, medical conditions, blood test results, imaging reports, medical scores, pharmacy contact information, prescription drug coverage from my previous insurers and information from my Québec Health Record (QHR). I also authorize UV Insurance to disclose such information to the third parties listed above. UV Insurance will collect and disclose only the personal information strictly necessary to review this request.

Please note that you may withdraw your consent to the disclosure or use of your personal information at any time. However, withdrawing your consent may result in legal or contractual consequences related to the administration of your insurance policy. UV Insurance will explain any such consequences to you, if applicable. To request a correction to your personal information (including information that is inaccurate, incomplete or outdated), to access your file or to withdraw your consent, you must submit a written request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud Street, Drummondville, QC J2C 7G7.

By signing below, the undersigned confirms that they have read and accepted the information contained in this form.

As a healthcare professional, I hereby declare that I am acting in accordance with the laws and regulations governing the protection of personal information. By signing this form, I confirm the accuracy of the information provided and that my patient has been informed of this information.

License # _____

X _____ Date

Y	M	D
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Healthcare professional's signature Signatory's name in block letters