

Please have the following form completed in full by your physician. This information is required to assess your request for coverage of a non-generic drug. To be eligible, proof of the medical justification code indicated below is required to authorize the reimbursement of a brand-name drug without the insured party having to pay the difference in price between the brand name drug and its generic equivalent.

SECTION 1 – TO BE COMPLETED BY PATIENT

Participant Name		SSQ Certificate No. (7 digits)	Employer Name		
Patient Name		Date of Birth Y Y Y Y M M D D		Telephone Number	
Street Address					
City		Province	Postal Code 		

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, clinic or medically related facility to give to SSQ information regarding my health. I hereby authorize SSQ to exchange information with other parties as required, only when the information is needed to administer this claim or to confirm the accuracy of this information.

Date Signature of patient _____

(If under 16 years of age, the signature of the plan member is required).

SECTION 2 – TO BE COMPLETED BY PHYSICIAN

Physician Name	License No.
I confirm that the information provided is true and I understand that an authorization could be repealed if, after verification, it is deemed ineligible as per SSQ's brand name prescription drug policy.	
Physician Signature	Date Y Y Y Y M M D D

SECTION 3 – DRUG REQUESTED FOR EVALUATION

Therapeutic justification for taking one or more brand-name drugs.

Code	Therapeutic justification
NPS A	Diagnosed allergy to an inactive ingredient used in the composition of the generic drug, but absent from the brand-name version.
NPS B	Diagnosed intolerance to an inactive ingredient used in the composition of the generic drug, but absent from the brand-name version.
Immuno	Prescription with the mention "Do not substitute/No substitutions" for an immunosuppressant (Azathioprine, Mycophenolate mofetil, Mycophenolate sodique, Sirolimus, Tacrolimus) .
Clozapine	Prescription with the mention "Do not substitute/No substitutions" for Clozapine.

Please complete the table below

Product name						
Code	<input type="checkbox"/> NPS A	<input type="checkbox"/> NPS B	<input type="checkbox"/> NPS A	<input type="checkbox"/> NPS B	<input type="checkbox"/> NPS A	<input type="checkbox"/> NPS B
	<input type="checkbox"/> Immuno	<input type="checkbox"/> Clozapine	<input type="checkbox"/> Immuno	<input type="checkbox"/> Clozapine	<input type="checkbox"/> Immuno	<input type="checkbox"/> Clozapine

SECTION 4 – CONTACT US

Return this form by **fax** to 1-855-453-3942

English toll free: 1-888-651-8181 • **French** toll free: 1-877-651-8080 ou www.ssq.ca

SSQ, Life Insurance Company Inc. is committed to keeping your information confidential.