PRIOR AUTHORIZATION REQUEST FORM / MEDICAL CANNABIS

DECLARATION OF THE INSURED PERSON

Section 1: Information about the plan member and the patient			
Name of plan member	Insurance policy / certificate	Name of employer	
Name of patient	Date of birth (YYYY/MM/DD)	Telephone	
Address (house number and street name)	City/Town	Province	Postal code

Section 2: Authorization to disclose personal information

I certify that the information in this prior authorization request is complete, accurate and true.

I authorize physicians and other health care professionals, medical, paramedical or clinical institutions, care coordinators, members of SSQ's Preferred Pharmacy Network (outside Quebec only) and any public or parapublic organization, including Régie de l 'assurance maladie du Québec, to disclose to SSQ, Life Insurance Company Inc. (SSQ) any of my relevant personal information including and without limitation, any medical information and medical evaluations in connection with the processing of this request. I hereby waive their confidentiality obligation and authorize them to disclose the requested information to SSQ. In addition, I authorize SSQ to disclose to the previously named third parties any of my relevant personal information including and without limitation any medical information and medical evaluations in connection with the processing of this request.

Photocopies of this document have the same value as the original.

Signature of **patient** (parent/legal guardian) _____ Date _____

IMPORTANT :

All correspondence concerning this form will be sent to the address indicated in the participant's file.

Send us this duly completed form by mail or by fax to: 1-855-453-3942.

Telephone: 418-651-2588/1-800-380-2588 – Fax: 1-855-453-3942 Address: 2525 Laurier Blvd, P.O. Box 10500, Quebec City, QC G1V 4H6

ssq.ca

PRIOR AUTHORIZATION REQUEST FORM /
MEDICAL CANNABIS

DECLARATION OF THE PRESCRIBER

Section 3: Information about the prescriber		
Name of prescriber	Specialty	Licence No.:
Telephone	Fax	
I hereby certify that the information in this request is complete, true and accurate: Signature of **prescriber** _____ Date_____		

IMPORTANT:

Please do not provide any genetic test results

Section 4: Clinical information

Diagnosis

❒ Chronic neuropathic pain that is unresponsive to standard therapies

❒ Cancer related pain that is unresponsive to standard therapies

❒ Spasticity secondary to multiple sclerosis or spinal cord injury that is unresponsive to standard therapies

❒ Nausea and vomiting caused by chemotherapy that is unresponsive to standard therapies

NOTE:

To be eligible for reimbursement, the medical cannabis must have been purchased solely from a licensed vendor duly authorized by Health Canada.

The expenses related to the production, administration, prescription, or procurement of medical cannabis are not eligible for reimbursement.

Please note that a reimbursement is possible only if your insurance contract includes the benefit “Cannabis for medical purposes”.

Please attach to your request a copy of **Health Canada's "Medical Document Authorizing the Use of Cannabis for Medical Purposes Under the Cannabis Regulations"** (or equivalent).

Section 5: Additional information