iA Financial Group

PRIOR AUTHORIZATION FORM
XENICAL

GROUP INSURANCE

Print

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5
Fax: 1-855-884-9811

All Other Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3
Fax: 1-877-780-7247

The purpose of this form is to obtain information required to assess your claim for Xenical. Xenical must satisfy the criteria for coverage under your plan.

PART 1 – MEMBER/PATIENT INFORMATION

Member name _____

Policy no. _____ Certificate no. _____

Patient name (if different) _____

Relationship to plan member _____ Date of birth Y M D _____

PART 2 – TO BE COMPLETED BY PHYSICIAN

We are in the process of reviewing a request received for Xenical prescribed for the above patient. Please provide us with the following information.

1. What is the patient's Body Mass Index? _____

2. What are the patient's current weight and height? _____

3. Has the patient been diagnosed with any specific illness(es) that are adversely affected by unhealthy body weight?

☐ No ☐ Yes If yes, please list these conditions.

_____

_____

_____

4. If diabetic, please specify the type: _____

5. What is the expected duration of the treatment? _____

Physician's last and first name _____

Address _____ Postal code _____

Telephone _____ Fax _____

Email _____

☐ General practitioner ☐ Specialist ☐ Other, specify _____

Signature X _____ Date Y M D _____

PART 3 – MEMBER CONFIRMATION/AUTHORIZATION

I AGREE that the statement included in this form will serve as basis to review my own or my dependent's drug claim.

If the drug claim being reviewed is for my dependent, I CONFIRM that I have the AUTHORIZATION to discuss the information about him or her with respect to the drug claim.

On behalf of myself and my dependent, I AUTHORIZE my physician or healthcare provider to disclose and exchange with Industrial Alliance Insurance and Financial Services Inc. (the "Company") the information requested in this form regarding the drug for myself or my dependent. I CONSENT to the release of the information in this form to the Company, its employees, agents and reinsurers. If my Social Insurance Number is used as my identification number, I authorize its use for the administration of my group benefits.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature X _____ Date Y M D _____

Address _____ Postal code _____

Tel. home _____ Tel. work _____ Extension _____