SSQ Financial Group

PRESCRIPTION DRUG
REQUEST FOR BRAND NAME DRUG COVERAGE

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 for coverage, there must be medical evidence indicating that an adverse reaction to the generic or clinically equivalent drug will occur if used.

SECTION 1 – TO BE COMPLETED BY PATIENT

Participant Name	SSQ Certificate No.	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 benefit or to confirm the accuracy of this information.

Date (Y Y Y Y M M D D) 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	Licence No.
Physician Signature	Date (Y Y Y Y M M D D)

Street Address

Telephone Number	Fax Number	
City	Province	Postal Code

SECTION 3 – DRUG REQUESTED FOR EVALUATION

Drug being requested:

DIN:	Strength and Dosage:

Diagnosis:	Duration of therapy:

Generic or clinically equivalent drug tried:

DIN:	Strength and Dosage:

Description of adverse reaction (nature, extent, severity):

Outcome attributed to adverse reaction (check all that apply):

Life Threatening ☐ Hospitalization ☐ Important Allergic Reaction ☐

Other (specify): _____

SECTION 4 – CONTACT US

www.ssq.ca

Return this form by mail or by fax to 1-855-453-3942
English 418-651-2551 or Toll Free 1-800-400-0023
French 418-651-2588 or Toll Free 1-800-380-2588

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