

SEE BACK OF FORM FOR PROCEDURES

- Please complete entire form. If information is missing from the form it will be returned to the member.
- Incomplete forms cannot be processed.
- Any costs associated with the completion of this form or obtaining additional medical information are the responsibility of the member.

PATIENT INFORMATION (To be completed by the member)

Member's Last Name and First Name		Group No. 141000	Certificate No.
Patient's Last Name and First Name		Date of birth YYYY MM DD	Telephone No. Area Code + Number
Number, Street, Apartment		City, Province	Postal Code

Have you already purchased your prescriptions requested by your physician below? Yes No If yes, please attach your paid-in-full receipt.

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the claim form is accurate and complete. I authorize Desjardins Financial Security, strictly for the purposes of managing my file and settling this claim to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, insurance companies; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, use the personal information it may have about me in existing files that are now closed. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of member _____

Signature of insured dependent aged 16 and over _____

Date _____

DRUGS REQUESTED FOR SPECIAL AUTHORIZATION

Product Name	Strength	Dosage	Quantity	Diagnosis

Expected duration of therapy _____ For injectables, facility where medication is administered _____

No previous treatment Previous treatment _____

Results from previous treatment **Relevant Lab Test Results**

<input type="checkbox"/> Successful	<input type="checkbox"/> Patient did not tolerate	
<input type="checkbox"/> Failed	<input type="checkbox"/> Contraindication	

If the products requested are in one of the categories below, please complete the applicable section in addition to the above.

MIGRAINE

of doses required per month _____ Frequency of attacks _____

1. Analgesics tried: No Yes _____

Results: Successful Failed
 Contraindication Patient did not tolerate

2. Prophylactic treatment tried: No Yes _____

Results: Successful Failed
 Contraindication Patient did not tolerate

3. Nasal/oral ergotamine tried: No Yes _____

Results: Successful Failed
 Contraindication Patient did not tolerate

For Renewals:
 Response to treatment _____

PROTON PUMP INHIBITORS

Diagnosis: Duodenal Ulcer Gastric Ulcer
 Reflux Esophagitis Other _____

Have Pariet and Generic Omeprazole been tried? Yes No

If no, specify medical reason _____

Results: Successful Failed
 Contraindication Patient did not tolerate

Severity of reflux on endoscopy _____

Description of other diagnosis _____

REMICADE, ENBREL, KINERET

Diagnosis _____

Dose and Frequency requested _____

Patient's Weight _____

Name of two DMARDs tried _____

Length of DMARD treatment _____

Facility where Remicade is administered _____

For Renewals:
 Response to treatment _____

ANGIOTENSIN RECEPTOR BLOCKERS

Diagnosis _____

Has patient tried ACE - inhibitor? Yes No

Results of treatment _____

BISPHOSPHONATES

Previous osteoporotic fracture: Yes No

Bone mineral density result _____

T-Score if no BMD _____

ALZHEIMER'S DISEASE TREATMENT

MMSE Score from last three months _____

ANTIEMETICS

of tablets required per cycle _____

of cycles of chemotherapy planned _____

MULTIPLE SCLEROSIS

EDSS Score _____

of exacerbations in last two years _____

Lesions on MRI and size _____

For Renewals:
 EDSS Score from last three months _____
 # of exacerbations in last year _____

Please note: This is not a request to have procedures completed, but to provide results if they have previously been completed.

PHYSICIAN INFORMATION

Physician Last Name and First Name (PLEASE PRINT)		Telephone No. ()	Fax No. ()
Number, Street, Office		City	Province Postal Code

Signature of physician _____ Date _____

PROCEDURES FOR SPECIAL AUTHORIZATION

- Special Authorization is a pre-approval process to determine if certain products will be reimbursed under your benefit plan.
- Eligible prescriptions must be purchased in a public pharmacy.
- Special authorization coverage is contingent on your continued status as a Desjardins Financial Security (DFS) cardholder or beneficiary.
- To be considered for reimbursement, please submit your original paid receipt to DFS.

This form must be completed by your attending physician and forwarded to:

**Desjardins Financial Security
P.O. Box 4358 Station A
Toronto ON M5W 3M3**

Upon receipt, the request will be confidentially reviewed according to payment criteria developed by DFS in consultation with health care consultants. In some cases, additional diagnostic or clinical information may be required. DFS will send you a written response.

Special Authorization may be limited to a specified time period and/or quantity of medication. Renewal of the Special Authorization will be considered by DFS upon request from the member. The renewal request should include information from the physician supporting continued use of the medication.

If the information on your form is complete, the usual turnaround time for assessment is seven to 10 working days. In cases where you require an urgent response due to a medical condition, every effort will be made to respond the same day. If you wish to have a response faxed back to you, request this in writing on your Special Authorization form. If you wish to know the status of your Special Authorization request, please call our Customer Service Centre at 1-877-838-7763.

NOTE TO PHYSICIAN

Under the Special Authorization program, DFS grants approval for payment of certain benefits if they fall within certain established criteria. By denying a request for Special Authorization, DFS is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.