Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com/planmember
1-800-263-1810

REQUEST FOR REIMBURSEMENT OF REFERENCE BIOLOGIC DRUGS

- **Any charges for the completion of this form are the member's responsibility.**
- **Please complete sections A and B and have your physician complete sections D and E. The exception will only be approved if the physician provides an acceptable medical reason to support why the patient is unable to take a biosimilar version of the reference biologic drug. This request will be assessed based on the medical information provided and may be reviewed by our physician or pharmacist.**

Section A. Patient's information (to be completed by the member)

Name of policyholder	Group No.	Certificate No.

Last name and first name of member	Date of birth YYYY MM DD

Address – No., street, apt.	City	Province	Postal code

Last name and first name of patient	Date of birth YYYY MM DD

Relationship to member	DIN (Drug Identification Number)

Section B. Declaration and authorization for the collection, use and communication of personal information

All the information I have provided on the claim form is accurate and complete. I acknowledge having read the Personal Information Management section at the back of the form. I authorize Desjardins Financial Security Life Assurance Company (DFS), hereinafter Desjardins Insurance, 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 healthcare 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. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. 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 the member: _____ **Date:** _____

Signature of the insured dependent aged 16 and over: _____ **Date:** _____

Telephone Nos: Home: _____ **Office:** _____ **Extension:** _____

Section C. Personal information management

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentations, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.

Please complete the Attending Physician section on the reverse.

PRINT NEW REQUEST

Section D. Physician's statement (to be completed by the physician)

ATTENTION
This form must be used to request an exemption from the transition to a biosimilar only.
No request for a reference drug will be considered if the patient is not already under treatment and reimbursed by a public or private drug plan.

1. Reference biologic drug requested: _____

2. Please specify the reason the patient cannot switch to a biosimilar version of the reference biologic drug:

☐ Pregnant patient – Due date: _____ YYYY-MM-DD

☐ Pediatric patient

☐ Patient for whom treatment with at least 2 other biologic drugs has failed

Please indicate the biologic drugs that were tried: _____

☐ Other – Please provide sufficiently documented medical justification.

Section E. Physician's identification (to be completed by the physician)

Last name and first name of physician (PLEASE PRINT)

_____

Address – No., street, suite | City | Province | Postal code

_____

Telephone No. | Fax No.

_____

Signature of the physician: **Date:**

Send form by fax: 418-838-2134 or 1-877-838-2134
or by mail: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6