THE Great-West Life ASSURANCE COMPANY

Request for Brand Name Drug Coverage

The information you provide on this form helps us assess your request for coverage of a brand name drug. To be eligible for this coverage, medical evidence must show that you experience adverse side effects from the generic version. If your request is approved, coverage may be granted for a set period of time, after which you'll need to re-apply for continued coverage. Assessment of your request may be delayed if this form is incomplete.

You're responsible for any fees associated with completing this form.

Complete the following section. Please print.

Plan member name	Patient name	
Plan name	Plan number	Plan member I.D. number
Date of birth (dd/mm/yyyy)	Home phone number	Work phone number
Address (number, street, city, province, postal code)		

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), refer to www.greatwestlife.com or write to Great-West Life's Chief Compliance Officer.

I authorize Great-West Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing my consent will help Great-West Life to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan member's signature: _____ Date: _____

Ask your prescribing physician to complete the following section. Please print.

Name of prescribing physician	Specialty	
Address (number, street, city, province, postal code)		
Phone number	Fax	
Brand name drug requested	DIN	Dosage/frequency
Generic drug prescribed	DIN	Dosage/frequency
Outcome attributed to adverse reaction (check all that apply) ☐ Life threatening ☐ Hospitalization ☐ Allergic reaction ☐ Other (specify) _____	Description of adverse reaction (nature, extent, severity)	
Anticipated duration of therapy	Prescriber's signature	Date (dd/mm/yyyy)

Please mail the completed form to:
The Great-West Life Assurance Company
Drug Services
PO Box 6000
Winnipeg MB R3C 3A5

or

Fax to: 1.204.946.7664
The Great-West Life Assurance Company
Attention: Drug Services

M7088-9/14

Clear