THE Great-West Life ASSURANCE COMPANY

Request for Drug Dosage Increase
For previously approved Prior Authorization Drugs

The purpose of this form is to obtain further information required to assess a claim for a drug at a dose that is outside of Health Canada's recommendations for the specific drug and condition.

IMPORTANT: Please answer all questions. Your claim assessment may be delayed if this form is incomplete or contains errors.

Any costs incurred for the completion of this form are the responsibility of the plan member/patient.

Please print

Part 1 Plan Member Information		
Plan Member:	Patient Name:	
Plan Name:	Plan Number:	Plan Member I.D. Number:
Patient Date of Birth (Day/Month/Year):	Home Phone Number (including area code):	Work Phone Number (including area code):
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 patient assistance programs 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: _____

M7268-3/15

THE Great-West Life ASSURANCE COMPANY

Physician's Questionnaire

Please have the below completed by your prescribing physician. Attach extra information if necessary.

Part 2 Physician Information

Name of prescribing physician (please print):	Specialty:
Address (number, street, city, province, postal code):	
Telephone Number (including area code):	Fax Number (including area code):

1. Prior Authorization Drug:
2. Requested Dosage and Frequency:
3. Date increased dosage was established or will be established:
4. Anticipated period of time this dosage will be maintained:
5. Date of physician appointment for assessment of response to the increased dosage:
6. Is there a plan to reduce dosage in the future? ☐ Yes ☐ No

   If yes, provide details: _____

   If no, provide rationale: _____
7. Has the patient undergone any therapeutic drug level testing or any other applicable test that could assess drug efficacy?

   ☐ Yes ☐ No ☐ Not applicable **Please attach reports.**
8. Please advise the medical rationale for the increased dosage.

   _____

   _____

   _____

   _____

Please provide the following documentation

- ☐ Clinical information including lab reports and scores prior to the increased dosage
- ☐ Clinical information including lab reports and scores since the increased dosage was established (if applicable)
- ☐ Provide clinical literature/studies to support the use of the increased dosage, such as:
  - ☐ At least two Phase II or two Phase III clinical trials showing consistent results of efficacy; and
  - ☐ Published recommendations in evidence-based guidelines supporting its use.

I certify that the information provided on this Physician's Questionnaire is true, correct and complete.

Physician's signature: _____ Date: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. The completed Request for Information form can be returned to Great-West Life by mail or fax.

Mail to: The Great-West Life Assurance Company
Drug Services
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: The Great-West Life Assurance Company
Fax 1.204.946.7664

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