



Application for Exception to the Formulary

The medication you are applying for as an exception will generally be covered under the second tier (the lower reimbursement percentage) of your plan. If the exception is approved, you will be able to receive reimbursement for this drug at the higher reimbursement.

You are responsible for any fees your Physician may charge to complete the Physician's statement section on the form, or fax the form to Manulife Financial.

To apply for an exception:

- A. Complete section 1, Plan member information.
- B. Complete section 3, Authorization to release information
- C. Have your physician complete section 2, Physician's statement
- D. Return this form to Manulife Financial - Group Benefits using either of the two methods outlined below

Fax Submissions	Mail Submissions
<p>If you live outside Quebec, fax your application to:</p> <p>(519) 883-0301</p> <p>If you live in Quebec, fax your application to:</p> <p>(514) 286-6737</p> <p>A letter confirming the decision will follow by mail.</p>	<p>If you live outside Quebec, mail your application to:</p> <p>Manulife Financial Group Benefits Group Health Claims PO Box 1653 Waterloo, ON N2J 4W1</p> <p>If you live in Quebec, mail your application to:</p> <p>Manulife Financial Group Benefits Group Health Claims PO Box 2580, Station B Montreal, QC H3B 5C6</p> <p>A letter confirming the decision will follow by mail.</p>

When can I expect a decision?

When we receive any exception request, we first determine if our specialists will need to review your case with our medical consultant.

A request that does not require a medical consultation will generally be processed within 3 business days. If we require information from our Medical Director, processing may take up to 5 days.

If your application is faxed, you will receive verbal confirmation of the decision, followed by written confirmation by mail. If you mailed your application, you will receive written confirmation of our decision by mail.

APPLICATION FOR EXCEPTION TO THE FORMULARY

Please return completed form to:

IF YOU LIVE OUTSIDE QUEBEC IF YOU LIVE IN QUEBEC

Manulife Financial Group Benefits
Group Health Claims
PO BOX 1653
Waterloo, ON N2J 4W1

Manulife Financial Group Benefits
Group Health Claims
PO BOX 2580, Station B
Montreal, QC H3B 5C6

Your Formulary Plan is highly comprehensive and will meet most of your prescription drug requirements. However, there may be instances where your physician may feel that a drug which is not listed on the formulary may be needed.

To apply for an exception, please complete the Authorization to Release Information and have your physician complete the questionnaire. This application will be assessed based on medical information provided and may be reviewed by our Medical Director for final decision.

1 Plan member information

You can obtain your plan no., account/division no. and your certificate no. from your I.D. card.

Patient information

Plan no.	Certificate no.	Plan sponsor		
Plan member name (first, middle initial, last)			Birthdate (dd/mm/yyyy)	
Plan member address (number, street and apt.)		City or town	Province	Postal code
Phone number ()				
Patient name		DIN	Birthdate (dd/mm/yyyy)	

Please note: Any charges for the completion of this form are your responsibility.

2 Physician's statement

To be completed by physician.

Physician's full name (first, middle initial, last)				
		City or town	Province	Postal code
Telephone Number ()				
Drug prescribed (chemical name, dosage form, strength):				
Please provide diagnosis necessitating the use of this drug.				
Please list any and all drug therapies previously used to treat this condition(s).				
Explain the results achieved for each drug and why these drug therapies were discontinued.				
Comments: Please add any additional information that you feel would be relevant to the application of this exception.				
Physician's signature			Date (dd/mm/yyyy)	

3 Authorization

I certify that the information in this form is true and complete, to the best of my knowledge.
I authorize any health care provider, other insurance company, any type of workers' compensation board, my plan sponsor, or other persons to release and exchange information requested by Manulife Financial, when the information is needed to process this claim.
I agree that a photocopy of this authorization shall be as valid as the original.

Please sign here

Signature of patient/or legal guardian

Date (dd/mm/yyyy)

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.