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OTIP RAEO®

OTIP Health Claims
PO Box 280
Waterloo ON N2J 4A4

1.866.783.6847 | www.otip.com

Request for Approval of Brand Name Drug

The prescribed drug you are applying for as an exception is covered up to the price of the lowest cost interchangeable drug. If this exception is approved, you will receive reimbursement up to the reasonable and customary price for the product dispensed.

The cost of the prescribed drug will only be considered under this plan, provided your physician prescribed a brand name drug instead of the lowest cost interchangeable drug because of an adverse reaction or therapeutic failure for the patient.

INSTRUCTIONS: (Please print all answers.)

1. Please complete sections 1, 2 and 4. Section 3 is to be completed by your physician.
2. Any charges for the completion of this form are your responsibility.
3. Please mail your completed form to the mailing address above.

SECTION 1: PLAN MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)			Gender ☐ Male ☐ Female
Address (Number, Street and Apt.)		City/Town	Province / Postal Code
Home Telephone Number	Work Telephone Number	Date of Birth *(mm/dd/yyyy)*	Plan Sponsor
OTIP Identification Number	Plan Number	Email Address	

SECTION 2: PATIENT INFORMATION (To be completed if different than Plan Member)

Patient's Name (First, Middle Initial and Last)	Date of Birth *(mm/dd/yyyy)*
Relationship to Plan Member (Insured)	

SECTION 3: PHYSICIAN'S STATEMENT (To be completed by your physician)

Physician Name (First, Middle Initial and Last)		Office Telephone Number
Address (Number, Street and Apt.)	City/Town	Province / Postal Code
Drug prescribed (chemical name, dosage form, strength)	DIN (Drug Identification Number)	What is the medical reason for the request? ☐ Adverse reaction ☐ Therapeutic failutre
Physician's signature		Date *(mm/dd/yyyy)*

SECTION 4: CERTIFICATION AND AUTHORIZATION

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. I authorize OTIP and the group benefits insurance carrier ("Insurer") that provides my benefits coverage to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). I am authorized by my Dependants to disclose and receive their Information, for the Purposes. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, the Insurer and their reinsurers and/or service providers, for the Purposes. I authorize the use of my OTIP ID number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or the Insurer's Privacy Policy available at www.manulife.com, or by request.

Signature of Plan Member **Date** *(mm/dd/yyyy)*

Any Information provided to or collected by the Insurer in accordance with this authorization, will be kept in a benefits health file.

Access to your Information will be limited to:

- The Insurer and their reinsurers and service providers 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, where appropriate, to have any inaccurate information corrected.

QUESTIONS? CONTACT OTIP BENEFITS SERVICES AT 1-866-783-6847