REQUEST FOR DRUG SUBSTITUTION

Use this form to request approval for drug substitution under your Extended Health Benefit Provisions. To be eligible for this substitution exception, there must be trials with at least two lower cost interchangeable drugs for the same condition and satisfactory medical evidence indicating an adverse reaction to ingredients in such interchangeable drugs.

1. TO BE COMPLETED BY MEMBER

Member Name		Group Number	Certificate Number (10 Digits)	
Patient Name	Relationship to Member **O** Member **O** Spouse **O** Child **O** Other		Address	
City	Province	Postal Code	Telephone number	Patient Date of Birth (mm/dd/yyyy)

I hereby authorize any physician, hospital, insurance company, other healthcare professional, Empire Life and its agents and third party service providers to exchange information in connection with this claim for the purpose of handling this substitution request, adjudication of claims, and administration of my health benefit plan I assume responsibility for any cost required for the completion of this form. A photocopy of this authorization shall be as valid as the original.

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

2. TO BE COMPLETED BY PRESCRIBING HEALTHCARE PROFESSIONAL (Please print clearly)

Healthcare Professional Name		Healthcare Professional Designation & Qualification	
Address (street name and number)		City	
Province	Postal Code	Telephone number	Fax number
Healthcare Professional Signature X			**Date** (mm/dd/yyyy)

Has the patient experienced an adverse drug reaction to ingredients in at least two lower cost interchangeable drug treatments for the same condition? **O Yes O No** (provide details below)

If there is only one lower cost alternative available for the prescribed drug, please indicate below.

LIST DRUGS PRESCRIBED FOR THIS CONDITION (to which an adverse reaction occurred)

Name of drug	Result
Reaction	Date (mm/dd/yyyy)
Name of drug	Result
Reaction	Date (/mm/dd/yyyy)

DRUG REQUESTED FOR SUBSTITUTION

Name of drug	Dosage	Frequency
Current Results	Reason for Request	Estimated Length of time required (ending date (mm/dd/yyyy)

Mail to Group Claims Department at address below, or, **Fax** to 1-855-619-0828, or, **Scan and Email** to group.csu@empire.ca.