

Prior Authorization Form

For rare diseases: Esbriet (pirfenidone)



Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Important – please read carefully

Please note that the completion of this form is not a guarantee of approval. It must be completed in full otherwise it will be returned to you. Any expense for medical evidence to support this request is your responsibility. Given the confidential nature of your information, we will issue our response to you in writing. If you have already purchased the medication for which you are requesting prior authorization, please attach all original receipts along with a regular extended health care claim form.

2 To be completed by plan member

Plan member information

Contract number		Member ID number		Your plan sponsor/employer	
Your last name			First name		<input type="checkbox"/> Male <input type="checkbox"/> Female
Your address (street number and name)					Date of birth (dd-mm-yyyy) _ _
Your address (street number and name)					Apartment or suite
City			Province		Postal code
Preferred language of correspondence <input type="checkbox"/> English <input type="checkbox"/> French		Daytime phone number		Fax number	
		_ _		_ _	

Claimant information

Claimant's last name		First name	
Date of birth (dd-mm-yyyy)		Relationship to plan member	
_ _		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	

Authorization and signature

I certify that the information I provided above is true and complete. I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this application including health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Plan member's signature	Date (dd-mm-yyyy)
X	_ _



3 To be completed by prescribing physician

Prescribing physician's last name (please print)	First name (please print)	
Specialty	Telephone number — —	
Address (street number and name)	Apartment or suite	
City	Province	Postal code
Drug name	Strength	Dose

Esbriet (pirfenidone) will be eligible for reimbursement only if the patient satisfies the criteria listed below. If the patient does not satisfy the criteria, then the drug will not be eligible for reimbursement (please confirm by checking off the last box below). The eligible expense under this plan is that portion of the expense that is not payable or available under a government-sponsored drug program or another drug plan.

If approved, approval for coverage of this drug may be reassessed at any time at Sun Life Assurance Company of Canada's discretion.

Please indicate if the patient satisfies the following criteria:

For the treatment of mild to moderate idiopathic pulmonary fibrosis (IPF) in adults.

OR

None of the above criteria applies.

Relevant additional information

Physician's signature X	Date (dd-mm-yyyy) — —
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Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or to obtain information about our privacy practices, send a written request by email to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Questions? Please visit www.sunlife.ca or call our toll-free number 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

Mailing instructions – keep a copy for your records

Mail or fax your completed form to the claims office nearest you.

Fax number: 1-855-342-9915

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