Public Service Health Care Plan
Dispense Fee Frequency
Limit Exception Form

PROTECTED "B" WHEN COMPLETED

The purpose of this form is to obtain the required information to assess a request for an exception to the dispense fee frequency limit under the Public Service Health Care Plan (PSHCP).

To be eligible for this coverage, an explanation must be provided that shows that you require this medication to be dispensed more frequently than every 3 months. If your request is approved, coverage may be granted for a set period, after which you will need to re-apply.

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

Any costs incurred for the completion of this form are not eligible for reimbursement under the PSHCP.

Canada Life recognizes and respects the importance of privacy. Personal information collected 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 Canada Life's personal information policies and practices (including with respect to service providers), refer to canadalife.com *or write to Canada Life's Chief Compliance Officer.*

Please refer to the PSHCP Privacy Statement *(canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html) for further information on how your privacy is protected. Where there is a difference between the* Privacy Act *(///laws-lois.justice.gc.ca/eng/acts/P-21/) and the PSHCP Privacy Statement and Canada Life's Privacy guidelines, Canada Life will apply the most stringent requirements.*

I authorize Canada Life, any healthcare or dentalcare provider, my plan sponsor, the Federal PSHCP Administration Authority, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when 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 consent will help Canada 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

In accordance with the Positive Enrolment Authorization and Declaration (welcome.canadalife.com/pshcp/review-authorizations-and-declarations.html) accepted during the completion of Positive Enrolment (refer to your Positive Enrolment Record if you completed Positive Enrolment by paper), I agree to the collection, use and disclosure of personal information as set out in the Privacy section, Canada Life's Privacy guidelines and the PSHCP Privacy Statement.

I certify that the information given below is true, correct and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

Plan Member's signature: _____ Date: _____

Instructions:

1. **Complete "Part 1 – Plan member and patient information" sections.**
2. **Have the prescribing health care provider complete the "Part 2 - Health care provider information" sections.**
3. **Send all pages of the completed form to us by mail, fax, or email as noted below.**

Mail: Drug Claims Management
The Canada Life Assurance Company
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: Drug Claims Management
Fax 1-204-946-7664

Email: cldrug.services@canadalife.com

For additional information, please visit the Canada Life PSHCP Member Services website at canadalife.com/PSHCP or contact the PSHCP Member Contact Centre at 1-855-415-4414, Monday to Friday from 8 am to 5 pm, your local time.

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us at 711 for TTY to Voice or 1-800-855-0511 for Voice to TTY.

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Public Service Health Care Plan Dispense Fee Frequency Limit Exception Form

PROTECTED "B" WHEN COMPLETED

Part 1 – Plan member and patient information

Plan member and patient information – Complete all sections (please print)

Plan member name:	Patient name, if different than plan member:	
Public Service Health Care Plan number: ☐ 052111 ☐ 052112 ☐ 052113 ☐ 052114 ☐ 052115	Certificate number:	Patient date of birth (mmm-dd-yyyy):

Address (number, street, city, province/territory, postal code):

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient.

Home phone number:	Work phone number:

Select the reason why the prescription drug is to be dispensed more frequently:

- ☐ a) safety or storage
- ☐ b) the co-pay for a three-month supply is more than $100
- ☐ c) a medical reason

If you answered a or b, please provide the following information. You don't have to ask your health care provider to complete the form.

Prescription drug information

Drug identification number (DIN):	Dosage/frequency:
Drug identification number (DIN):	Dosage/frequency:

If you answered c, please ask your prescribing health care provider to complete the following section.

Part 2 – Health care provider information

Health care provider information (please print)

Name of health care provider:	Specialty:

Address (number, street, city, province/territory, postal code):

Telephone number (including area code):	Fax number (including area code):
Drug identification number (DIN):	Dosage/frequency:
Drug identification number (DIN):	Dosage/frequency:

Medical rationale for drug to be dispensed more frequently:

Anticipated duration of therapy:

I certify that the information provided is true, correct and complete.

Health care provider's signature: _____ Date: _____

License number: _____

It is important to provide detailed information to help avoid delays in assessing this request. The completed form can be returned to Canada Life by mail, fax, or email.

Mail: Drug Claims Management
The Canada Life Assurance Company
PO Box 6000
Winnipeg MB R3C 3A5

Fax: Drug Claims Management
1-204-946-7664

Email: cldrug.services@canadalife.com

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