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A Better Place For You®

GROUP BENEFITS
MIGRAINE MEDICATION
SUPPLEMENTAL SUPPLY REQUEST FORM

INSTRUCTIONS

Mail: Co-operators Life Insurance Company
Extended Health Care Claims
1920 College Avenue
Regina, SK S4P 1C4

Fax: (306) 761-7101

PART 1 — PATIENT INFORMATION

Group _____ Account _____ Certificate _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Patient _____ (First Name) _____ (Initial) _____ (Last Name)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Date of Birth _____ (MMM/DD/YYYY) Relationship to Plan Member _____

PART 2 — PHYSICIAN INFORMATION

Physician _____ (First Name) _____ (Initial) _____ (Last Name) Specialty _____

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Telephone Number (_____) _____ Fax Number (_____) _____

Name of Requested Drug _____ DIN _____ Strength _____

Quantity requested per 30 days _____ Please list how many migraine headaches the patient experiences, per month, on average. _____

Has the patient tried medications to prevent migraine headaches from re-occurring? ☐ Yes ☐ No

If yes, please list all medications the patient is currently using for migraine prevention. _____

If the patient is no longer using preventative therapy, please indicate why preventative therapy was discontinued. Please list which medications were tried, the dosing, and the period of time in which the preventative medication(s) were used. _____

Has the patient tried and failed at least two (2) other therapies to treat a migraine headache? ☐ Yes ☐ No

If yes, please list all medications the patient has tried in the past to treat a migraine, how long the medication was used for, and the reasons for discontinuing.

Has the patient been seen by a neurologist or headache specialist in the past year? ☐ Yes ☐ No

Is yes, please indicate the date of consult. _____

Is the patient taking this medication in combination with another therapy to treat migraine headaches? ☐ Yes ☐ No

If yes, please provide details _____

Please describe any underlying medical condition(s) that may necessitate the current dosing. _____

I hereby certify that the information provided in this request is true, complete and accurate.

Physician Signature _____ Date _____ (MMM/DD/YYYY)

(SEE REVERSE)

PART 3 — PATIENT/GUARDIAN AUTHORIZATION

Co-operators Life Insurance Company Privacy Statement
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I authorize Co-operators Life Insurance Company (a) to use the personal information disclosed on this form, and any other personal information known to Co-operators Life Insurance Company regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

I hereby certify that the information provided in this request is true, complete and accurate.

Patient/Legal Guardian Name _____ Telephone Number (_____) _____

Signature of Patient/Legal Guardian _____ Date _____
MMM/DD/YYYY