

Request for Approval of Brand Name Drug:

Along with the enclosed requested form, please have the physician provide additional information as to the details of the Adverse Reaction and/or Therapeutic Failure. Please note that failure to provide this information will result in the return of this form in order to obtain the missing information.

Manulife Financial

For your future™

Group Benefits Request for Approval of Brand-Name Drug

The prescribed drug you are applying for as an exception is covered up to the lowest cost interchangeable price. 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 the prescribing physician indicates that the lowest cost interchangeable drug cannot be tolerated or is ineffective for the patient.

To apply for an exception, please complete Sections 1 and 3 and have your physician complete Section 2.

| | Plan contract number | Plan member certificate number | Plan sponsor name | rname | | |
|--|---|--|---|--|--|--|
| You can obtain your plan number and your certificate number from your ID card. | Plan member name (first, middle initial, last) | | | Date of birth (dd/mmm/yyy) | | |
| | Address (number, street, apartment) | | City | Province | Postal code | |
| | Patient's name (first, middle initial, last) | | | Date of birth (dd/mmm/yyy) | | |
| | Relationship to insured | | | DIN (Drug Identification Number) | | |
| Physician's statement | Drug prescribed (chemical name, dosage form, strength) In order for the cost of the prescribed drug to be considered under this policy, you must select the applicable medical reason below indicating why the lowest cost interchangeable drug cannot be tolerated or is ineffective for this patient. Adverse reaction. Therapeutic failure | | | | | |
| To be completed by physician Please note: Any charges | | | | | | |
| for the completion of this form are the plan member's responsibility. | Physician's name (first, middle initial, last) | | | Physician's telephone number () | | |
| | Physician's address (number, str | eet, suite) | City | Province | Postal code | |
| | Physician's signature | | | Date signed (dd/mmm/yyyy) | | |
| | Leertify 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. Lauthorize Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). Lam authorized by my Dependants to disclose and receive their Information, for the Purposes. Lauthorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. Lauthorize the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. Lagree a photocopy or electronic version of this authorization is valid. Lunderstand that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/planmember, or from my Plan Sponsor. | | | | | |
| Please sign and date here. | Signature of plan member | | | Date signed (dd/mmm/yyyy) | | |
| Mailing instructions | Please send the completed form to the following address: | | | | | |
| | Johnson Inc. Attention: LISA GAUDET | | | Г | | |
| | 650 Montgomery Street P.O. Box 1176 Stn A Email: lgaudet@johnsor | | | n.ca | | |
| | Fredericton, NB E3B 5C8 | Fa. | x: (506) 458-1172 | | | |
| | Physician's statement To be completed by physician Please note: Any charges for the completion of this form are the plan member's responsibility. Authorization | You can obtain your plan number and your certificate number from your ID card. Plan member name (first, middle initial address (number, street, apartment) Patient's name (first, middle initial Relationship to insured) Physician's statement To be completed by physician Please note: Any charges for the completion of this form are the plan member's responsibility. Physician's name (first, middle in Physician's name (first, middle in Physician's name (first, middle in Physician's signature) Authorization Lertify that I, my spouse a services claimed and that the Manulife Financial ("Manulife ("Information, for the Purpose health professionals, facilitie insurer, investigative agency exchange this information we purposes. Lauthorize the use administration, if my SIN is to of this authorization is valid available at www.manulife.cc Signature of plan member Mailing instructions Please send the complete Johnson Inc. 650 Montgomery Street | Plan member name (first, middle initial, last) Address (number, street, apartment) Patient's name (first, middle initial, last) Plan member name (first, middle initial, last) Plan member name (first, middle initial, last) Patient's name (first, middle initial, last) Relationship to insured Plan prescribed (chemical name, dosage form, strength) In order for the cost of the prescribed drug to be considered under tindicating why the lowest cost interchangeable drug cannot be tolendown and the completion of this promate the plan member's responsibility. 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Box 1176 Stn A En | Plan member name (first, middle initial, last) Physician's statement To be completed by physician Please note: Any charges for the completion of this form are the plan member's responsibility. Physician's address (number, street, southern for the cost of the prescribed drug to be considered under this policy, you must select the indicating why the lowest cost interchangeable drug cannot be tolerated or is ineffective for this form are the plan member's responsibility. Physician's address (number, street, suite) City Physician's address (number, street, suite) City Authorization Lecrify that I, my spouse and/or my dependants of minor or major age ("Dependant sor discovers exaction") for the purposes of Group Benefits plan administration, audit and the management of this daim ("Purposes"). Lam authorized by my Dependants to dis Information, for the Purposes I authorize any person or organization with Information for the Purposes and my lan member certificate information information, for the purposes of the benefits programs to exchange this information with each other and with Manuffic, Its reinsurers and/or if Purposes . Lauthorize the use of my Social Insurance Number ("SIN") for the purposes of this authorization is valid. Lunderstand that Manuffic, Its reinsurers and/or if Purposes . Lauthorize the use of my Social Insurance Number ("SIN") for the purposes . Lauthorize the use of my Social Insurance Number ("SIN") for the purposes . Lauthorize the use of my Social Insurance Number ("SIN") for the purposes . Lauthorize the use of my Social Insurance Number ("SIN") for the purposes of this authorization is valid. Lunderstand that Manuffic is reinsurers and/or if the purposes . Lauthorize the use of my Social Insurance Number ("SIN") for the purposes . 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Physician's name (first, middle initial, last) Physician's name (first, middle initial, last) Physician's name (first, middle initial, last) Physician's statement In order for the cost of the prescribed drug to be considered under this policy, you must select the applicable middle initial, last) Physician's name (first, middle initial, last) Physician's address (number, street, sulte) Physician's signature Date of this patient. Physician's signature Date of this patient. Authorization I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have reservices daimed and that the information provided for this dain is the and content. 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