Prior Authorization Form

For sleeping medications: Imovane (or generic zopiclone) and Starnoc (zaleplon – *subject to availability*)

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

Please print clearly and be sure all sections are complete to avoid delays in processing. Retain a copy of this form for your records.

1. Please complete Section A.
2. Please have your physician complete Section B. *You are responsible for any cost required by your physician to complete this form.*
3. Please fax the form to TELUS Health Solutions at 1-866-840-1509, or mail it to TELUS Health Solutions, 4141 Dixie Road, PO Box 41154, Mississauga, ON L4W 5C9.
4. If you have any questions, please call 1-800-361-6212.

A Information to be completed by patient

We will get back to you with our decision within 2 business days from the date we receive all the information necessary to make a decision. Notifications occur Monday to Friday, between 9 a.m. and 4 p.m. Eastern Standard Time.

Plan member's last name	First name
Drug card number	
Patient's last name	First name
Patient's date of birth (dd-mm-yyyy)	Relationship to plan member ☐ Plan member ☐ Spouse ☐ Dependent

Contact information: Given the confidential nature of your information, please specify how you want to be notified of our decision on your request for coverage.

☐ contact my pharmacy:

Pharmacy name	Telephone number

☐ call me (and leave a message if I'm not there) at:

☐ email me at:

☐ fax me at:

I certify that the information I provided above is true and complete. I authorize Sun Life Assurance Company of Canada, its reinsurers, its agents and service providers to collect, use and disclose my personal information needed for underwriting, administration and adjudicating claims under this Plan to any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I understand that information about me pertaining to this claim may be reviewed in the event this Plan is audited. I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Signature of patient/parent/legal guardian	Date (dd-mm-yyyy)
X	

B Information to be completed by prescribing physician

Drug name	Strength	Dose

Non-benzodiazepine hypnotics will be eligible for reimbursement only if the patient satisfies the criteria listed below. If the patient does not satisfy any of 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.

Please indicate if the patient satisfies the following criteria:

☐ Patient has been treated unsuccessfully OR experienced adverse effects with a benzodiazepine hypnotic.

☐ Patient has one or more medical condition(s) described under the Warning or Contraindication sections of the respective product monograph for benzodiazepine use.

OR

☐ None of the above criteria applies.

Physician's last name		First name
License number	**Telephone number**	**Fax number**
	– –	– –
Address (street number and name)		**Apartment or suite**
City	**Province**	**Postal code**
Physician's signature		**Date (dd-mm-yyyy)**
X		– –