La Mutuelle Strategys
Fiducie de santé au bénéfice des employés

Autorisation form
Exceptional medication

1. Participant

Plan member Name	Patient name	
Plan name	Policy number	Member certificate number
Date of birth (dd/mm/yyyy)	Home phone number	Work phone number
Address (Number, street, city, province, postal code)		

2. Medical Professional

Doctor name	Specialty	
Address (Number, street, city, province, postal code)		
Telephone number	Fax number	
Brand name perscribed	DIN	Dose/Frequency
Generic perscribed	DIN	Dose/Frequency

3.Therapeutic Indication and Treatment Objective

Diagnosis and therapeutic indication:

Therapeutic objective:

4.Information on the chronicity of the condition to be treated, within the meaning of the regulation *

Date of onset of symptoms, complications or manifestations of the disease:

If the condition being treated is episodic, specify the frequency and duration of the episodes:

5.Information on the seriousness of the condition to be treated, within the meaning of the regulation *

If treatment with the drug that is the subject of this application is already started, respond to the condition of the person before the start of this treatment.

A. Please specify the degree of physical functional limitation related to the diagnosis:

Types of activities	Degree of limitation *	* index :
Physical activities (walking, climbing stairs, lifting an object or other)		0 = no limitation 1 = slight limitation 2 = moderate limitation 3 = severe limitation 4 = extreme limitation
Daily activities at home (personal hygiene, meal preparation, household or other)		
Daily activities outside the home (employment, recreation, sport or other)		
Social activities (restaurant meals, movies, family visits, volunteering or other)		

B. In the absence of physical impairment, is there a risk that this person's condition or complications will affect his condition in terms of morbidity or mortality?

☐ No ☐ Yes If yes, specify:

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6.Information on the seriousness of the condition to be treated within the meaning of the regulation * (cont'd)

C. If this person has psychological impairment resulting from the condition being treated, please describe and describe the severity of the impairment:

D. If a scale of assessment of the severity of the condition to be treated exists or examination results are available, please provide them (eg, similar visual scale). If it is a symptom, describe its intensity, frequency and duration:

E. Has a specialty investigation been performed? Specify:
Include the results of clinical examinations relevant to this application, including a specialty investigation report, if applicable (for example, imaging, T score, laboratory values).

7.Information to Determine Whether the Medicine Subject of this Application Is a Last Resort, as Set Out in the Regulations *

A. Specify the medical treatments and medications received to treat this condition, the dosage of these drugs, the duration of these treatments and the reason for their discontinuation:

B.Which other medications and medical treatments known to be effective for the treatment of this condition cannot be prescribed because of the particular circumstances of this case? Specify:

C.If treatment with the drug that is the subject of this application has started, specify the start date and the observed beneficial effects:

8. Other information related to this person's particular situation

9.Signature of the prescriber Date : dd/mm/yyyy

Return this form:

By Fax : 1-877-820-7302
Keep the original

Mail : Strategys Mutual
Services des réclamations
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La Prairie, Quebec
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