Desjardins Financial Security®

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Print

AUTHORIZATION REQUEST
DRUG OR PATIENT EXCEPTIONS

A - IDENTIFICATION : PHYSICIAN ☐ OR DENTIST ☐

Last name	First name	
Address - Number, street		Licence No.
City / Province	Postal code	Phone No. (Area code + Number)

B - PATIENT' S IDENTIFICATION

Patient's last name and first name

Member's last name and first name

Address - Number, street, apartment			Contract or group or policy No.
City	Province	Postal code	Certificate No.

Phone Nos : Home : (Area code + Number) Office : (Area code + Number)

C - DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Brand name	Form	Concentration
Posology	Treatment Scheduled : From: To:	

If this is an injectable drug, please specify the establishment where it is administered:

D - JUSTIFICATION FOR REQUEST

Diagnosis

Signature of physician or dentist: Date:

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