

**Eylea (afibercept)**

The purpose of this form is to obtain the medical information required to assess your request for a drug on the Prior Authorization list under your drug plan benefit coverage. To avoid delays in processing your request, please ensure that all information, including contact information is complete. Completion of this form is not a guarantee of approval. If you have already purchased the drug, please attach all original receipts along with an Extended Health Care Claim form. All costs incurred to complete this form are the plan member's responsibility. If you are registered for the Plan Member Secure Site and have provided an email address, you will receive an email notification when the prior authorization decision is available on your claims statement. If you are not registered on the Plan Member Secure Site, you will be notified of the prior authorization decision by mail.

**Important: Please ensure the most current unaltered version of the form is completed and signed. To download the most recent version of the Drug Prior Authorization form go to [www.manulife.ca](http://www.manulife.ca).**

| <b>1 – Plan member and patient information</b> |  |                                    |                                |                         |              | <b>To be completed by plan member</b>  |             |
|------------------------------------------------|--|------------------------------------|--------------------------------|-------------------------|--------------|----------------------------------------|-------------|
| Plan contract number                           |  |                                    | Plan member certificate number |                         | Plan sponsor |                                        |             |
| Plan member name (first)                       |  | Plan member name (middle initial)  |                                | Plan member name (last) |              | Plan member Date of birth (dd/mm/yyyy) |             |
| Plan member address (number, street)           |  |                                    | Address (suite)                |                         | City or town |                                        | Province    |
|                                                |  |                                    |                                |                         |              |                                        | Postal code |
| Patient name (first)                           |  | Patient name (middle initial)      |                                | Patient name (last)     |              | Patient date of birth (dd/mm/yyyy)     |             |
|                                                |  |                                    |                                |                         |              | Relationship to plan member            |             |
| Patient's preferred daytime phone number       |  | Patient's email address (optional) |                                |                         |              |                                        |             |
|                                                |  |                                    |                                |                         |              |                                        |             |

| <b>1A – Other Group Plan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>1B – Recent Coverage Change</b> |  |                      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--|----------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Does the patient have drug coverage under any other group plan? If Yes, please complete below: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;">Name of insurance company</td> </tr> <tr> <td style="padding: 5px;">Plan contract number</td> <td style="padding: 5px;">Plan member certificate number</td> </tr> </table> <p>Is this drug covered under the other group plan? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If no, why was the drug declined by the other group plan? Please attach the other group plan decline notice (typically a letter or statement). We need this decline notice to see if this drug can be approved. If this is a renewal a current decline notice is required.</p> | Name of insurance company          |  | Plan contract number | Plan member certificate number | <p>Did your plan sponsor recently transfer your drug benefits to Manulife? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>Before joining Manulife, were you receiving coverage for this drug through your previous insurance company? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If Yes, attach proof of payment (a copy of a pharmacy receipt showing payment from prior insurance company or an Explanation of Benefits from the prior insurance company). Proceed to section 7.</p> |
| Name of insurance company                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                    |  |                      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Plan contract number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Plan member certificate number     |  |                      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| <b>2 – Provincial Plans</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>To be completed by plan member</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| <p>Most provinces offer some form of drug coverage to their residents. Your Manulife drug plan supplements the coverage provided by provincial plans. It is important that you or your doctor (if required) apply to the applicable provincial program to ensure there are no delays in your drug reimbursement. Check with your doctor or login to the <b>Manulife Provincial Drug Plans Resource Centre</b> on our Plan Member Secure Site at <a href="http://www.manulife.ca/planmember">www.manulife.ca/planmember</a> to confirm if the drug you have been prescribed may be eligible for coverage under a provincial plan. If the drug you have been prescribed is listed under a provincial program, you will need to apply to the program before consideration can be given under your Manulife drug plan.</p> |                                       |
| <p>Has application been made to the provincial program for coverage? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <div style="border: 1px solid black; padding: 5px; min-height: 30px;">If no, why?</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |
| <p>Has the patient been approved for coverage by the provincial program for this drug? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <div style="border: 1px solid black; padding: 5px; min-height: 30px;">If no, advise why the request was declined?</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                       |
| <p><b>In Ontario, for patients that qualify for coverage under the Exceptional Access Program (EAP), if the drug is an EAP drug, a copy of the approval or denial from EAP must be submitted with this form so Manulife can complete the assessment of this request.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |

| <b>3 – Patient Assistance Programs</b>                                                                                                                                                                                          | <b>To be completed by plan member</b> |                    |                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------|---------------------------------------|
| <p>Have you enrolled in the Patient Assistance Program for the requested drug? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If yes, please provide the details below:</p> |                                       |                    |                                       |
| Case Manager Name (first)                                                                                                                                                                                                       | Case Manager name (last)              | Case Manager Phone | Case Manager Email                    |
| Patient Assistance Program Name                                                                                                                                                                                                 |                                       |                    | Patient Assistance Program ID Number: |

| 4 – Medical information                                                                                                                             |  |                                              |              | To be completed by prescribing physician                 |             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--------------|----------------------------------------------------------|-------------|
| Drug strength and dosage                                                                                                                            |  |                                              |              |                                                          |             |
| Where will treatment be administered?                                                                                                               |  |                                              |              |                                                          |             |
| <input type="checkbox"/> Home                                                                                                                       |  | <input type="checkbox"/> MD office           |              | <input type="checkbox"/> Private Clinic                  |             |
|                                                                                                                                                     |  | <input type="checkbox"/> Hospital/In-Patient |              | <input type="checkbox"/> Hospital/Out-patient            |             |
| Is the MD office located in a hospital?                                                                                                             |  |                                              |              |                                                          |             |
|                                                                                                                                                     |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered in the MD office or in another area of the hospital? (describe below)                                                 |  |                                              |              |                                                          |             |
|                                                                                                                                                     |  |                                              |              |                                                          |             |
| If the treatment is not being administered at home, please provide:                                                                                 |  |                                              |              |                                                          |             |
| Name of private clinic/hospital                                                                                                                     |  |                                              |              | Telephone number                                         |             |
| Address (number, street)                                                                                                                            |  | Address (suite)                              | City or town |                                                          | Province    |
|                                                                                                                                                     |  |                                              |              |                                                          | Postal code |
| Please select the diagnosis for which the drug has been prescribed and respond to the corresponding questions.                                      |  |                                              |              |                                                          |             |
| <input type="checkbox"/> <b>Neovascular (Wet) Age-Related Macular Degeneration (AMD) - Initial Criteria</b>                                         |  |                                              |              |                                                          |             |
| Is the patient 18 years of age or older?                                                                                                            |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Does the patient have neovascular (wet) age-related macular degeneration (AMD)?                                                                     |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered outside of the hospital?                                                                                              |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| <input type="checkbox"/> <b>Neovascular (Wet) Age-Related Macular Degeneration (AMD) - Renewal Criteria</b>                                         |  |                                              |              |                                                          |             |
| Is there documented objective evidence of continued benefit for the patient based on ophthalmologist's judgment of visual and/or anatomic outcomes? |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered outside of the hospital?                                                                                              |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| <input type="checkbox"/> <b>Macular Edema secondary to Central Retinal Vein Occlusion (CRVO) - Initial Criteria</b>                                 |  |                                              |              |                                                          |             |
| Is the patient 18 years of age or older?                                                                                                            |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Does the patient have visual impairment due to macular edema secondary to central retinal vein occlusion (CRVO)?                                    |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered outside of the hospital?                                                                                              |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| <input type="checkbox"/> <b>Macular Edema secondary to Central Retinal Vein Occlusion (CRVO) - Renewal Criteria</b>                                 |  |                                              |              |                                                          |             |
| Is there documented objective evidence of continued benefit for the patient based on ophthalmologist's judgment of visual and/or anatomic outcomes? |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered outside of the hospital?                                                                                              |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| <input type="checkbox"/> <b>Macular Edema secondary to Branch Retinal Vein Occlusion (BRVO) - Initial Criteria</b>                                  |  |                                              |              |                                                          |             |
| Is the patient 18 years of age or older?                                                                                                            |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Does the patient have visual impairment due to macular edema secondary to branch retinal vein occlusion (BRVO)?                                     |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered outside of the hospital?                                                                                              |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| <input type="checkbox"/> <b>Macular Edema secondary to Branch Retinal Vein Occlusion (BRVO) - Renewal Criteria</b>                                  |  |                                              |              |                                                          |             |
| Is there documented objective evidence of continued benefit for the patient based on ophthalmologist's judgment of visual and/or anatomic outcomes? |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |
| Will the drug be administered outside of the hospital?                                                                                              |  |                                              |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |

| 4 – Medical information (continued)                                                                                                                                                                  |                          | To be completed by prescribing physician |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------|-----------------------------|
| <input type="checkbox"/> <b>Diabetic Macular Edema (DME) - Initial Criteria</b>                                                                                                                      |                          |                                          |                             |
| Is the patient 18 years of age or older?                                                                                                                                                             |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| Does the patient have diabetic macular edema (DME)?                                                                                                                                                  |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| Will the drug be administered outside of the hospital?                                                                                                                                               |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| <input type="checkbox"/> <b>Diabetic Macular Edema (DME) - Renewal Criteria</b>                                                                                                                      |                          |                                          |                             |
| Is there documented objective evidence of continued benefit for the patient based on ophthalmologist's judgment of visual and/or anatomic outcomes?                                                  |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| Will the drug be administered outside of the hospital?                                                                                                                                               |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| <input type="checkbox"/> <b>Myopic Choroidal Neovascularization (mCNV) - Initial Criteria</b>                                                                                                        |                          |                                          |                             |
| Is the patient 18 years of age or older?                                                                                                                                                             |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| Does the patient have myopic choroidal neovascularization (myopic CNV)?                                                                                                                              |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| Will the drug be administered outside of the hospital?                                                                                                                                               |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| <input type="checkbox"/> <b>Myopic Choroidal Neovascularization (mCNV) - Renewal Criteria</b>                                                                                                        |                          |                                          |                             |
| Will additional doses only be administered if monitoring reveals signs of disease activity (e.g., reduced visual acuity and/or signs of lesion activity)?                                            |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| Will the drug be administered outside of the hospital?                                                                                                                                               |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| <input type="checkbox"/> <b>Retinopathy of Prematurity (ROP) - Initial Criteria</b>                                                                                                                  |                          |                                          |                             |
| Does the patient have retinopathy of prematurity (ROP), classified according to the International Classification for ROP in at least one eye as one of the following ( <i>check which applies</i> ): |                          |                                          |                             |
| • Zone I Stage 1 plus, or 2 plus, or 3 non-plus or 3 plus                                                                                                                                            | <input type="checkbox"/> |                                          |                             |
| • Zone II Stage 2 plus or 3 plus                                                                                                                                                                     | <input type="checkbox"/> |                                          |                             |
| • Aggressive posterior retinopathy of prematurity (AP-ROP)                                                                                                                                           | <input type="checkbox"/> |                                          |                             |
| Will the drug be administered outside of the hospital?                                                                                                                                               |                          | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
| <input type="checkbox"/> <b>Any Other Diagnosis</b>                                                                                                                                                  |                          |                                          |                             |
| Please provide the specific diagnosis and any Canadian clinical research that supports the use of this drug in your patient's context.                                                               |                          |                                          |                             |
|                                                                                                                                                                                                      |                          |                                          |                             |

| 5 – Drug history                                                                                                                                                                                                                                                                                                                                                                                                     |                       |                                     | To be completed by prescribing physician                                                                                                    |           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| If no previous therapies have been tried for the selected diagnosis, please specify the rationale:<br><input type="checkbox"/> Risk of drug interaction <input type="checkbox"/> Patient has contraindication<br><input type="checkbox"/> Other                                                                                                                                                                      |                       |                                     |                                                                                                                                             |           |
| Please provide medical rationale                                                                                                                                                                                                                                                                                                                                                                                     |                       |                                     |                                                                                                                                             |           |
| For the selected diagnosis, please provide all previous and current drug therapies in the area below:                                                                                                                                                                                                                                                                                                                |                       |                                     |                                                                                                                                             |           |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm) | End date (yyyy/mmm)                 | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |           |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                       |                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |           |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm) | End date (yyyy/mmm)                 | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |           |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                       |                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |           |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm) | End date (yyyy/mmm)                 | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |           |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                       |                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |           |
| Drug name                                                                                                                                                                                                                                                                                                                                                                                                            | Start date (yyyy/mmm) | End date (yyyy/mmm)                 | Specify Outcome:<br><input type="checkbox"/> Intolerance (Allergy/Adverse Event)<br><input type="checkbox"/> Inadequate/Suboptimal Response |           |
| Will the patient be continuing this medication in addition to new therapy?                                                                                                                                                                                                                                                                                                                                           |                       |                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |           |
| 6 – Physician information                                                                                                                                                                                                                                                                                                                                                                                            |                       |                                     |                                                                                                                                             |           |
| Prescribing physician's name (first)                                                                                                                                                                                                                                                                                                                                                                                 |                       | Prescribing physician's name (last) | College/License Number                                                                                                                      | Specialty |
| Address (number, street)                                                                                                                                                                                                                                                                                                                                                                                             |                       |                                     | Address (suite)                                                                                                                             |           |
| City or town                                                                                                                                                                                                                                                                                                                                                                                                         |                       | Province                            | Postal code                                                                                                                                 |           |
| Telephone number      Extension                                                                                                                                                                                                                                                                                                                                                                                      |                       | Fax number                          |                                                                                                                                             |           |
| Physician authorization                                                                                                                                                                                                                                                                                                                                                                                              |                       |                                     |                                                                                                                                             |           |
| I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits health file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein. |                       |                                     |                                                                                                                                             |           |
| Physician Signature                                                                                                                                                                                                                                                                                                                                                                                                  |                       |                                     | Date (dd/mmm/yyyy)                                                                                                                          |           |

**I certify** that I, my spouse and/or my dependents of minor or major age ("Dependents") require the drug named on this form (or an equivalent drug that Manulife proposes).

**I authorize:**

Manulife and/or its service providers, its reinsurers, and their service providers to collect, use, maintain and disclose my personal information related to this application ("Personal Information") for the purposes of:

- The assessment of the drug authorization request
- Managing my Group Benefits plan
- Assessing and processing claims
- Auditing and investigation of claims
- Patient assistance programs, if applicable
- And/or other purposes identified in the Personal Information Statement for Employers' Group Benefits plans (collectively, the "Purposes").

Any person or organization who has Personal Information about me that is required for Manulife to assess this drug authorization request, including any medical and health care professionals, institution, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.

**I understand:**

- A Manulife approved pharmacy vendor may engage me in the capacity of case management to provide support as part of this program. I acknowledge that participation in this program is entirely voluntary. My decision to participate will not have any impact on the assessment of my claim.
- If my Manulife plan recommends purchasing a drug that requires prior authorization from a preferred pharmacy or provider, a case manager may contact me, my doctor and/or patient assistance program to arrange to have my prescription(s) transferred to the preferred pharmacy or provider.
- That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and may be subject to the laws of those jurisdictions.
- I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind or terminate my claim.

**I agree:**

- A photocopy or electronic version of this consent is valid.
- I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate.
- Requests can be sent to: Privacy Officer Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6 or [Canada\\_Privacy@manulife.ca](mailto:Canada_Privacy@manulife.ca)
- For more information, I can review the [Personal Information Statement for Employers' Group Benefits Plans](#) and the [Canadian Privacy Policy](#).

**I confirm** that:

- The information I have given in this request is true and accurate.
- By signing, I give permission to and/or confirm that I have obtained the individual's consent for the collection, use, disclosure or otherwise processing of the individual's Personal Information for the Purposes (as these terms are defined above).

Plan member's signature

Date signed (dd/mm/yyyy)

Protecting your personal information is important to us. People who can see your personal information are:

- Manulife employees who need to see your information to do their jobs.
- People you've given permission to.

To find out more about Manulife's privacy policy please see [manulife.ca](http://manulife.ca)

## 8 – Submission instructions

### Plan Member Secure Site

1. Log in to the **Plan Member Secure Site**.
2. Choose “**Claims**”
3. Go to “**Submit a Claim.**”
4. Under **Service Provider**, select “**Other.**”
5. Choose “**Estimate**” as the **Claim Type**.

### Mobile App Site

1. Open the **Mobile Site** on your device.
2. Select “**Submit a Claim.**”
3. Choose “**Estimate**” as the **Claim Type**.

### Mail or fax

If you live in Quebec:

Manulife Group Benefits Health Claims  
Attention Prior Authorization Team  
PO BOX 2580, STATION B  
MONTREAL QC H3B 5C6

Fax: 1-855-752-0404

If you live outside Quebec:

Manulife Group Benefits Health Claims  
Attention Prior Authorization Team  
PO BOX 1653  
WATERLOO ON N2J 4W1

Fax: 1-855-752-0404

Please retain a photocopy for your files.

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