MEDAVIE BLUE CROSS™

PO BOX 220 MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 506-867-4580

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST

SEE BACK OF FORM FOR PROCEDURES

THIS FORM PREVIOUSLY FAXED (DATE): _____

Please complete **entire** form. If information is missing from the form it will be returned to the member. Incomplete forms cannot be processed. **Any costs associated with the completion of this form or obtaining additional medical information are the responsibility of the patient/member.**

PATIENT INFORMATION (To be completed by the Member/Patient.)

Member Name: _____ ID Number: _____ Policy Number: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Patient Name: _____ Date of Birth (dd/mm/yyyy): _____ Telephone Number: _____

* Have you already purchased your prescription requested by your physician below? ❑ Yes ❑ No

If you have already submitted your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt. Date (dd/mm/yyyy): _____ **OR**

Please attach your paid-in-full receipt with this request form.

OTHER COVERAGE

Do you or any dependents have other coverage under any other plan? ❑ Yes ❑ No **If Yes, complete the following:**

Name of other Insurer: _____ Member Name: _____

ID No: _____ Policy No.: _____

MEMBER STATEMENT

I hereby authorize any health care provider to release to Medavie Blue Cross, any medical information about myself and my dependents which relates to claims submitted by us, or on our behalf, to Medavie Blue Cross.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the member of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature of Patient (parent/guardian): _____ Date: _____
(If under 18 years of age the signature of the member is required.)

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information on privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

PHYSICIAN INFORMATION

Physician Name (Please Print) _____ Telephone Number: _____ Fax Number: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Physician Signature: _____ Date (dd/mm/yyyy): _____

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Product Name	Strength	Dosage	Quantity	Diagnosis

Expected duration of therapy _____ For injectables, facility where medication is administered _____

❑ No previous treatment ❑ Previous treatment (please specify) _____

If the product requested is in one of the categories below, please complete the applicable section in addition to the above.

MIGRAINE

of doses required per month _____ Frequency of attacks _____

Analgesics tried ❑ No ❑ Yes _____

Prophylactic treatment tried ❑ No ❑ Yes ❑ Presently being used

Results: ❑ Successful ❑ Failed
❑ Contraindication ❑ Did not tolerate

Has there been a consultation with a neurologist? ❑ No ❑ Yes

BIOLOGICAL RESPONSE MODIFIERS

Diagnosis _____

Dose and frequency requested _____

Patient's Weight _____

DMARDS doesn't apply to psoriasis and ankylosing spondylitis

Name of two DMARDs tried _____

Length of DMARD treatment _____

Applies only to psoriasis

Have systemic therapy and photochemical therapy been tried? ❑ No ❑ Yes

What is the CD4 Count and the percentage of BSA affected by psoriasis? _____

LONG-ACTING BRONCHODILATORS AND LEUKOTRIENE RECEPTOR ANTAGONISTS

Diagnosis _____

Is the patient presently using optimum inhaled steriods and still requiring short-acting bronchodilators more than three times weekly? ❑ No ❑ Yes

ANOREXIANTS

Please provide a current BMI result _____

Are there any existing comorbid conditions? (please specify) _____

NASAL STEROIDS

Beclomethasone and budesonide are regular benefits. Have they been tried? ❑ No ❑ Yes If not, is there any medical reason why they cannot be tried? (please specify) _____

ALZHEIMER'S DISEASE TREATMENT

MMSE Score within the last three months _____

FAMVIR, VALTREX, ZOVIRAX

Please specify if treating oral herpes, genital herpes, or herpes zoster

Is the patient immunocompromised? ❑ No ❑ Yes

If for oral herpes, and not immunocompromised, please describe extent of area affected

PROTON PUMP INHIBITORS

Diagnosis: ❑ Duodenal Ulcer ❑ Gastric Ulcer
❑ Reflux Esophagitis ❑ Other _____

Pariet, Tecta and generic Omeprazole are regular benefits. Have 2 out of the 3 medications been tried? ❑ No ❑ Yes

If not, is there any medical reason why they cannot be tried? ❑ No ❑ Yes

Please specify reason _____

Description of other diagnosis _____

MS DRUGS

EDSS Score: _____

# of exacerbations in last two years _____

Lesions on MRI and size _____

For Renewals:

EDSS Score within the last three months _____

# of exacerbations in last year _____

PROCEDURES FOR SPECIAL AUTHORIZATION

- Special Authorization is a pre-approval process to determine if certain products will be reimbursed under your benefit plan.
- Eligible prescriptions must be purchased at a Medavie Blue Cross approved provider.
- Special authorization coverage is contingent on your continued status as a Medavie Blue Cross cardholder or beneficiary.
- If your plan is based on reimbursement, submit your original paid-in-full receipt to Medavie Blue Cross to be considered for reimbursement.

This form must be completed by your attending physician and forwarded to:

Private and Confidential
Medavie Blue Cross
Special Authorization - Prescription Drugs
PO Box 220
Moncton NB E1C 8L3
or fax (506) 867-4580 (Confidential Line)

Upon receipt, this request will be confidentially reviewed according to payment criteria developed by Medavie Blue Cross in consultation with independent health care consultants. In some cases, additional diagnostic or clinical information may be required. Medavie Blue Cross will send you a written response.

Special Authorization may be limited to a specified time period and/or quantity of medication. Renewal of the Special Authorization will be considered by Medavie Blue Cross upon request from the patient/member. The renewal request should include information from the physician supporting continued use of the medication.

If the information on your form is complete, the usual turnaround time for assessment is seven to 10 working days. In cases where you require an urgent response due to a medical condition, every effort will be made to respond the same day. If you wish to have a response faxed back to you, request this in writing on your Special Authorization form. If you wish to know the status of your Special Authorization request, please call our Customer Service Centre at 1-800-667-4511.

NOTE TO PHYSICIAN

Under the Special Authorization program, Medavie Blue Cross grants approval for payment of certain benefits if they fall within certain established criteria. By denying a request for Special Authorization, Medavie Blue Cross is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.