



## Request For Prior Authorization

### Complete and Submit Your Request

Any plan member who is prescribed a medication that requires prior authorization needs to complete and submit this form. Any fees for the completion of this form are the responsibility of the patient.

#### 3 Easy Steps

- STEP 1** Plan Member completes Section 1.
- STEP 2** Prescribing doctor completes Section 2.
- STEP 3** Fax or mail the completed form to Express Scripts Canada®.

**Fax:**  
Express Scripts Canada Clinical Services  
(905) 712-6329

**Mail:**  
Express Scripts Canada Clinical Services  
2915 Argentia Road, Unit 7 Mississauga,  
ON L5N 8G6

### Approval Process

Completion and submission of this form is not a guarantee of approval. Plan members will receive reimbursement for the prior authorization drug through their private drug benefit plan only if the request has been reviewed and approved by Express Scripts Canada.

The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based medicine.

Please note that you have the right to appeal the decision made by Express Scripts Canada.

### Notification

The plan member will be notified whether their request has been approved or denied. The decision will also be communicated to the prescribing doctor by fax, if requested.

**Please continue to page 2.**



## Request For Prior Authorization

### Section 1 – Plan Member

Please complete this section and then take the form to your doctor for completion.

First Name:	Last Name:
Date of Birth (DD/MM/YYYY):     /     /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	
City:	Province:
Postal Code:	Telephone:
Insurance Carrier:	
Group #:	Client ID:
Relationship: <input type="checkbox"/> Cardholder/Plan Member <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant	

### Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

\_\_\_\_\_   
Plan Member Signature

\_\_\_\_\_   
Date

**Please continue to page 3.**



### Request For Prior Authorization

#### Section 2 – Prescribing Doctor

Drugs in the Prior Authorization Program may be eligible for reimbursement only if the patient does not qualify for reimbursement under a provincial plan and if the patient uses the drug(s) for Health Canada approved indication(s).

Please provide information on your patient's medical condition and drug history, as required by the group benefit provider to reimburse this medication.

Please note: All information requested below is mandatory for the approval process, any fields left blank will result in an automatic rejection. Please fill any non-applicable fields with 'N/A'. Supplemental information for this drug reimbursement request will be accepted.

<p>Please check the appropriate box:</p> <p><input type="checkbox"/> First time Prior Authorization application                      <input type="checkbox"/> Prior Authorization Renewal</p>
<p>Medication brand name and chemical name:</p>
<p>Indication/Medical condition:</p>
<p>The stage/severity/type of the patient's medical condition:</p>
<p>Any additional information relevant to the patient's medical condition and treatment (for example, labvalues, symptoms, genetic tests, health status assessments, BMI):</p>
<p>Drug dosage and administration, duration of treatment (Include frequency and number of cycles if for cancer treatment):</p>
<p>Concurrent therapy or therapies for the same treating condition (both pharmacological and non-pharmacological):</p>

Please continue to page 4.



### Request For Prior Authorization

Indicate name(s) of previously tried therapies:	Inadequate/Suboptimal Response	Allergy/Drug Intolerance
_____		<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

Regarding the site of drug administration, please indicate:

The type of setting (ex: home, hospital, private clinic): \_\_\_\_\_

The name of healthcare facility/hospital/clinic: \_\_\_\_\_

If this medication is to be administered in a hospital, please check below if the patient will be treated as:

Inpatient                       Outpatient

Has the patient applied for reimbursement under a provincial plan?

Yes. Which provincial program was the application made to? \_\_\_\_\_

No. Why not? \_\_\_\_\_

What was the outcome?     Approved             Denied

Additional Comments/Notes:

  
  
  

Physician's Name:	Specialty:
Address:	
Tel:	Fax:
License No.:	
Doctor Signature:	Date:
Do you want to be informed of the decision?	<input type="checkbox"/> Yes, by fax <input type="checkbox"/> No