

EAP TRANSITION FORM



Express Scripts Canada®
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

Where OHIP+ has previously paid claims for a drug:

1. Submit the claim electronically to the insurer on or after April 1, 2019 to determine if Prior Authorization (PA) is required.
2. If you receive the CPhA response code **LH – Prior authorization required**, please complete this form, **print and affix a copy of the patient’s EAP approval letter, if applicable, or the previously paid prescription receipt**, showing payment of this drug by OHIP+ (dated prior to April 1, 2019) and fax to (905) 712-6329.
3. Please allow time for processing. Submission of this form is not a guarantee of coverage.

DATE: _____

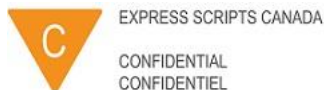
Section 1: To be completed by Pharmacist:

Drug Name and DIN number:	Drug strength and frequency:
EAP expiry date for this drug (if known):	Signature of Pharmacist:
Pharmacy Telephone Number:	Carrier No:
Policy or Group number:	Certificate number:

Section 2: To be completed by Plan Member or Pharmacist:

Patient’s Name (First, Last)	Patient’s Date of Birth (DD/MM/YYYY)
Plan Member’s Name (First, Last)	Signature of Patient/Guardian:
Plan Member Signature:	Relationship to Patient: (member/spouse/dependent)
Are you enrolled in a Patient Support Program? <input type="checkbox"/> Yes <input type="checkbox"/> No * If yes state which program:	

Affix patient receipt.



Telephone: 905-712-8615

