# 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?<br>☐ Yes ☐ No * If yes state which program: | |

**Affix patient receipt.**