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 related to the completion of this form are the responsibility of the plan member.

3 Easy Steps

STEP 1 Plan Member completes Part A.

STEP 2 Prescribing doctor completes Part B.

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
5770 Hurontario Street, 10th Floor,
Mississauga, ON L5R 3G5

Review Process

Completion and submission of this form is not a guarantee of approval. Plan members will receive reimbursement for the prior authorized 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 clinical protocols.

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.

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Part A – Primary cardholder and Patient

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

Primary cardholder information

First Name:		Last Name:
Insurance Carrier Name/Number:		
Group number:		Client ID:
Date of Birth (DD/MM/YYYY): / /		Gender: ☐ Male ☐ Female
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Patient information (if patient is primary cardholder, skip this section)

Patient's relationship to primary cardholder: ☐ Spouse ☐ Dependent	
First Name:	Last Name:
Date of Birth (DD/MM/YYYY): / /	Gender: ☐ Male ☐ Female

Is the patient enrolled in any patient support program? ☐ Yes ☐ No

Do you provide consent to allow Express Scripts Canada to contact the patient support program for obtaining additional information for purpose of completing this prior authorization evaluation, if required?
☐ Yes ☐ No

If Yes, provide program name, contact name and phone number: _____

_____

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 (DD/MM/YYYY)

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

☐ First time Prior Authorization application for this drug **Fill sections 1,2,4 and 5**

☐ Prior Authorization Renewal for this drug **Fill sections 1,3, 4 and 5**

Section 1 – Drug requested

Brand and chemical name:			
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration
Indication/Medical condition:			
Will this drug be used according to its Health Canada approved indication(s)? ☐ Yes ☐ No			

Section 2 – First-time application

The severity/stage/type of the patient's condition (ex: specify monthly frequency and duration for migraines, fibrosis status for Hepatitis C patient, etc.) *(please do **not** provide genetic test information or results)*
Additional information relevant to the patient's condition and treatment (ex: lab values such as LDL and IgE levels, health status assessments, BMI, symptoms) *(please do **not** provide genetic test information or results)*
Therapies (pharmacological/non-pharmacological) that will be used for treating the same condition concomitantly:

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Section 2 - Continued

Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate/ Suboptimal response	Allergy/ Drug Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Section 3 – Renewal information

Date of treatment initiation (DD/MM/YYYY):

Details on clinical response to requested drug – ex: PASI/BASDAI, laboratory tests, etc. *(please do **not** provide genetic test information or results)*

Section 4 – Drug administration and provincial coverage information

What is the site of drug administration?

☐ Home ☐ Doctor office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

Has the patient applied for reimbursement under a provincial plan?

☐ Yes. Specify which provincial program: _____

What was the outcome? ☐ Approved ☐ Denied ***Attach provincial decision letter with this form****

☐ No. Why not? _____

Additional Comments/Notes:

Section 5 – Prescriber information

Physician's Name:	Specialty:
Address:	
Tel:	Fax:
License No.:	
Do you want to be informed of the decision? ☐ Yes, by fax ☐ No	
Physician Signature:	Date (DD/MM/YYYY):