BLUE CROSS®

NATIONAL DRUG PRIOR AUTHORIZATION REQUEST

PROCEDURES FOR PRIOR AUTHORIZATION

COMPLETED FORMS CAN BE FAXED IN CONFIDENCE TO:

ATLANTIC PROVINCES & ONTARIO
PO Box Moncton NB E1C 8L3
Tel: 1-800-667-4511 Fax: 1-844-661-2640

QUEBEC
PO Box 3300, Station B Montreal QC H3B 4Y5
Tel: 1-888-873-9200 Fax: 1-514-286-8480

MANITOBA & NUNAVUT
PO Box 1046 Stn Main Winnipeg MB R3C 2X7
TEL: 1-888-873-9200 FAX: 204-772-1231

SASKATCHEWAN
516 2nd Avenue N PO Box 4030 Saskatoon SK S7K 3T2
TEL: 1-888-873-9200 FAX: 306-667-5860

ALBERTA & NORTHWEST TERRITORIES
10009 108 Street NW Edmonton, AB T5J 3C5
Tel: 1-866-998-8480 Fax: 1-877-828-4106

BRITISH COLUMBIA & YUKON
4250 Canada Way Burnaby, BC V5G 4W6
Tel: 1-888-873-9200 Fax: 604-419-2990

Upon receipt, this request will be confidentially reviewed according to payment criteria developed by Blue Cross in consultation with independent health care consultants. In some cases, additional testing including but not limited to diagnostic, genetic etc. or clinical information may be required in order to assess your request.

If the information on your form is complete, the usual turnaround time for assessment is 5 to 7 working days.

- Prior Authorization is a pre-approval process to determine if certain products will be reimbursed under a member's benefit plan.
- Please complete the entire form. Incomplete forms cannot be processed.
- **Prior to approval certain medications may require confirmed enrollment into the respective Patient Support Program.**
- To be eligible for reimbursement Blue Cross may require drugs be purchased at a designated pharmacy. Prior Authorization may be limited to a specified time period and/or quantity of medication.
- In cases where a request for Prior Authorization is declined, Blue Cross is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.
- Any costs associated with the completion of this form or obtainment of additional medical information are the responsibility of the member.
- Renewal of the Prior Authorization will be considered by Blue Cross upon request from the patient/member. The renewal request should include information from the physician supporting continued use of the medication.
- Prior Authorization coverage is contingent on your continued status as a Blue Cross cardholder or beneficiary.
- If this is a request under the Mesure du patient d'exception for a Quebec resident, please include a completed RAMQ Patient d'exception form in addition to this document.

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1 COORDINATOR INFORMATION

This section is to be completed by the Professional coordinating the request on behalf of the member (PSP, Cancer Care Navigator or Pharmacy)

Decision Communication Preference: ☐ Fax ☐ Telephone

Name of Program/Pharmacy: _____

Contact Name: _____

Contact Number: _____ Fax Number: _____

2 POLICY INFORMATION

Plan Member Name: _____

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

Telephone Number: _____ Policy Number: _____ ID Number: _____

3 PATIENT INFORMATION

Part A

Is Patient also the Plan Member? ☐ Yes ☐ No ☐ Current Address same as above (if not please complete applicable fields below)

Patient Name (if not plan member): _____

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

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

Do you have valid Medicare coverage in current province of residence? ☐ Yes ☐ No

Part B - Coordination of Benefits

Do you or any dependents have coverage for this drug under any other plan or program? ☐ Yes ☐ No **If Yes, complete the following:**

Policy Number: _____ Carrier: _____

(If applicable, please attach Explanation of Benefits completed form)

If the patient is a dependent, provide the birth day and month of the cardholder for the other carrier _____ (dd/mm)

Public Funded Program - Have you applied for coverage through a public funded program? ☐ Yes ☐ No

If yes, specify program name: _____

If no, please indicate why: _____

Part C - Authorization

I hereby authorize any health care provider to release to Blue Cross, any medical information about myself and my dependents which relates to claims submitted by us, or on our behalf, to 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 Blue Cross and/or Blue Cross Life Insurance Company of Canada and/or British Columbia Life & Casualty Company (BC life), 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 Blue Cross to collect, use and disclose my personal information as described above.

Signature of Patient: _____ Date: _____ (dd/mm/yyyy)

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 Blue Cross, call 1-888-873-9200.

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4 DRUG INFORMATION

Patient Support Program (PSP) Enrollment

Is patient enrolled in the Manufacturer Patient Support Program? ☐ Yes ☐ No

If Yes, Specify Program Name: _____ Program ID #: _____

PSP phone #: _____ PSP Fax #: _____

Product Name	Strength	Dosage	Frequency	Diagnosis

Patient Weight: _____ ☐ lbs ☐ kg

Expected Duration of Therapy. _____ Was treatment initiated in hospital? ☐ Yes ☐ No

Where is medication being administered? _____

What other treatments have been tried and what were the results? Please provide any scores or lab data which would support the diagnosis and severity of disease.

Please indicate any additional information you feel would be beneficial to assist our clinical team in reviewing this request:

5 PHYSICIAN STATEMENT

Physician Name: _____ Specialty: _____

Telephone Number: _____ Fax Number: _____

Physician Signature: _____ Date: _____