



PO BOX 220 MONCTON NB E1C 8L3 TEL: 1-800-667-4511 FAX: 1-844-661-2640 PO BOX 3300, STATION B MONTREAL QC H3B 4Y5 TEL: 1-888-873-9200 FAX: 1-514-286-8480



## PROCEDURES FOR PRIOR AUTHORIZATION

Completed forms can be faxed in confidence to 1-514-286-8480 for residents of Quebec and 1-844-661-2640 for residents of all other provinces

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 clinical and/or diagnostic information may be required in order to process your claim.

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 <u>entire</u> 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.
- If you would like more information about our Patient First Network, including how your Patient Support Program can become integrated with our new enhanced prior authorization processes, please send an email to: patientfirstnetwork@medavie.bluecross.ca



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COORDINATOR INFORMATION			
This section is to be completed by the Pro	-	on behalf of the member (PSF	R, Cancer Care Navigator or Pharmacy)
Decision Communication Preference: O Fa	•		
Name of Program/Pharmacy:			
Contact Number			
Contact Number:	Fax Num	ber:	
POLICY INFORMATION —			
Plan Member Name:			
Address:			Postal Code:
Telephone Number:			
PATIENT INFORMATION			
Part A			
Is Patient also the Plan Member? O Yes O	No O Current Address same	e as above (if not please com	nlete annlicable fields below)
Patient Name (if not plan member):		· · ·	
Address:			Postal Code:
Telephone Number:	ID Number:	Date of Birtl	n:(dd/mm/yyyy)
Do you have valid Medicare coverage in curre			
Please attach your paid-in-full receipt with this			
of the oldest receipt.			
Date:(dd/mm/yyyy)			
Part B - Coordination of Benefits			
Do you or any dependents have coverage for			
Policy Number:			
, ,,	se attach Explanation of Benefits fro		
If the patient is a dependent, provide the birth			(dd/mm)
Public Funded Program - Have you applied for If no, please indicate why:		rogram? O Yes O No	
Part C - Authorization			
I hereby authorize any health care provide relates to claims submitted by us, or on or		edical information about m	yself and my dependents which
I understand that the personal information provide and/or Blue Cross Life Insurance Company of C I am an eligible member, to recommend suitable carry, limited personal information may be collectare professionals or institutions, life and health and other third parties when required to administ	anada, may be collected, used, or disc products and services to me, and to reted from and/or released to a third par insurers, government and regulatory a	closed to administer the terms manage Blue Cross's business rty. These third parties include authorities, the member of any	of my policy or the group policy of which Depending on the type of coverage I other Blue Cross organizations, health policy under which I am a participant
I understand that my personal information will be instances doing so may prevent Blue Cross from needed and I am aware of the risks and benefits	n providing me with the requested cover	erage or benefits. I understan	
I authorize Blue Cross to collect, use and disclos	se my personal information as describe	ed above.	
Signature of Patient:		Date:	(dd/mm/yyyy)
A photocopy of this authorization shall be as vali on privacy policies at Blue Cross, visit <a href="https://www.med">www.med</a>			rivacy laws. For additional information



s patient enrolled in the Manufacturer	Patient Support Program? O Yes O N			
	-			
		Program ID #:		
SP pnone #:	-ax #:			
Product Name	Strength Dosage	Diagnosis		
PPLICABLE TO MULTIPLE SCLE	ROSIS (MS) DRUGS ONLY			
DSS Score:	# of Exacerbations in la	2 years: Lesions on M	RI & Size:	
atient Weight:				
cpected Duration of Therapy		Was treatment initiated in	nospital? O Yes O No	
here is medication being administer	ed?			
hat other treatments have been tried	d and what were the results?			
lease indicate any additional informa	ation you feel would be beneficial to assist	ur clinical team in reviewing this reques	st:	
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PHYSICIAN STATEMENT —				
PHYSICIAN STATEMENT —	ation you feel would be beneficial to assist			
Physician Name:		Specialty:		