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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 Medavie Blue Cross in consultation with independent health care consultants. In some cases, additional clinical or diagnostic information may be required to process your claim.

For Quebec residents, the criteria for prior authorization are adjusted to meet the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

- Prior Authorization is a pre-approval process to determine if certain products will be reimbursed under a member's benefit plan.
- Please complete entire form. Incomplete forms cannot be processed.
- For certain medications, approval for reimbursement may be conditional on confirmation of enrollment in the patient support program.
- Prior Authorization may be limited to a specified period or quantity of medication.
 Some Medavie Blue Cross plans may require you to purchase a drug requiring prior authorization from a preferred pharmacy*. If your prior authorization request is approved, a case manager may contact you, your physician, or Patient Assistance Program to provide information about the program and to arrange to have your prescription transferred to the preferred pharmacy.
 - *Not applicable in Quebec.
- In cases where a request for Prior Authorization is declined, Medavie 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 Medavie 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 Medavie 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 *Patient d'exception* form that can be found here: www.medaviebc.ca/en/resources, 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 e-mail to: patientfirstnetwork@medavie.bluecross.ca.

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1 PHARMACY INFORMATION	
This section is to be completed by the Professional coordinating the re Pharmacy)	quest on behalf of the member (PSP, Cancer Care Navigator or
Decision communication preference:	Telephone, Number:
Name of Program/Pharmacy:	
Contact Name:	Contact E-mail:
2 PATIENT INFORMATION	
Part A	
Patient Name:	Date of Birth:
E-mail address of patient (or of legal guardian if patient is underage):	(mm/dd/yyyy)
Address:	Suite: City:
Province: Postal Code:	Telephone Number:
Policy Number: ID Number:	
Do you have valid Medicare coverage in your current province of residence?	☐ Yes ☐ No
Have you already purchased this prescription?	☐ Yes ☐ No
Please attach your paid-in-full receipt with this request form. If you have alre your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to Medavie Blue Cross, please indicate the date of the oldest receipt to the oldest receipt	
Part B – Coordination of Benefits	
Do you or any dependant have coverage for this drug under any other plan	or program?
Policy Number:	Carrier:
(If applicable, please attach Explanation of Benefits from prior carrier with complete for	m)
If the patient is a dependent, provide the birth day and month of the cardhold	ler for the other carrier:(mm/dd)
Public-Funded Program – Have you applied for coverage through a public-fu	
If No, please indicate why:	
Part C – Authorization	
	d and used by Medavie Blue Cross to administer the terms of my policy or the ducts and services that I am eligible for as a member of a policy, and other nent at www.medaviebc.ca.
released to following third parties as required for the purposes of administe	ch as claim, health and/or financial related data may be collected from and/or tring and managing the benefits outlined in the policy of which I am an eligible surance companies, regulatory authorities and investigative bodies, services nt.
Where allowed by law, my information may be shared with Medavie Blue collected. If I am a resident of Quebec, this includes transferring or disciproviders outside of that province.	Cross employees or service providers in jurisdictions other than where it was osing my personal information to Medavie Blue Cross employees or service
I understand that my consent is only valid for the time it is needed to achieve my consent at any time. However, in some instances doing so may preven may be useful to me and/or my dependents. This consent complies with federal consent	the purposes outlined herein, unless I withdraw it. I understand I may withdraw t Medavie Blue Cross from providing me with certain products or services that eral and provincial privacy laws.
For more details about our information practices, including how your persor you have concerns or questions, please see our Medavie Blue Cross Privacy	nal information is protected, how to access or correct personal information, or if y Statement available at www.medaviebc.ca or call 1-800-667-4511.
Signature of Patient:	Date:

Residents of All Other Provinces
PO BOX 220, MONCTON (NB) E1C 8L3
TEL.: 1-800-667-4511 FAX: 1-844-661-2640

Residents of Quebec PO BOX 3300, STATION B, MONTREAL (QC) H3B 4Y5 TEL.: 1-888-588-1212 FAX: 1-514-286-8480



E-mail address of patient or of lega) Number:	
	pport Program?			
dicate the name of the Patient Sup SP phone #:			PSP Fax #:	
Product Name	Stren	ngth Dosage	e	Diagnosis
CONTRAVE (NALTREXONE / BUPRO	OPION)			
XENICAL (ORLISTAT)				
Patient weight:	☐ lbs ☐ kg	Date of d	iagnosis:	mm/dd/yyyy)
Expected duration of treatment:				mm/dd/yyyy) : is work related: ☐ Yes ☐ No
Was treatment initiated in hospital?				d?
ndicate the specialty of the physic	ian who initiated or	recommended the t	reatment:	
s the patient currently on, or previo	ously been on this	drug? ☐ No ☐ Y	es, indicate the treatr	nent start date:
	covering this drug: se provide a pharma	cy receipt showing pure	chase of this drug)	
	ete sections 3B an	nd 3D. For Renewal	s, please complete s	sections 3C and 3D.
Illowing drug categories (relative Obesity: weight management me	previously tried, on the contract of the contr	or could not be trie is) must be provide	d because of contra ed, including details	indications. The information for the on the contraindication if applicable.
Initial Request lease list all the drugs that were llowing drug categories (relative	previously tried, on the contract of the contr	or could not be trie is) must be provide axenda, Contrave, Wo Start Date	d because of contra ed, including details egovy), GLP-1 agonist	indications. The information for the on the contraindication if applicable.
B Initial Request ease list all the drugs that were llowing drug categories (relative Obesity: weight management me Trulicity, Rybelsus, Mounjaro)	previously tried, on the description of the description of the decarding o	or could not be trie is) must be provide axenda, Contrave, W	d because of contra ed, including details egovy), GLP-1 agonist	indications. The information for the on the contraindication if applicable. or other injectable incretin (Victoza, Ozempic,
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B Initial Request lease list all the drugs that were llowing drug categories (relative Obesity: weight management me Trulicity, Rybelsus, Mounjaro)	previously tried, on the description of the description of the decarding o	or could not be trie is) must be provide axenda, Contrave, Wo Start Date	d because of contra ed, including details egovy), GLP-1 agonist	indications. The information for the on the contraindication if applicable. or other injectable incretin (Victoza, Ozempic,

SPECIALTY DRUG INFORMATION me of patient: Date of Birth: licy Number: ID Number: mail address of patient or of legal guardian if patient is underage:						
Init	tial Request (cont'd)					
Clir	Clinical information					
	Assessment of the patient before the start of the treatment requested on this form					
	Date of evaluation:	(mm/dd/yyyy)				
	Weight:	lbs				
	Height (in cm):	cm				
	BMI:	kg/m²				
icui	uction? → If yes, specify the diet and, if no, indicate why	☐ Yes ☐ No				
		cal activity for chronic weight management? ☐ Yes ☐ No				
Is th	□ If yes, specify the diet and, if no, indicate why □	cal activity for chronic weight management? ☐ Yes ☐ No				
Is th	If yes, specify the diet and, if no, indicate why ne patient engaging in an increased level of physi If no, indicate why:	cal activity for chronic weight management? Yes No	_			
Is th	If yes, specify the diet and, if no, indicate why ne patient engaging in an increased level of physi If no, indicate why: ne patient currently taking a GLP-1 agonist or other	cal activity for chronic weight management? Yes No	_			
Is the	If yes, specify the diet and, if no, indicate why ne patient engaging in an increased level of physi If no, indicate why: ne patient currently taking a GLP-1 agonist or othe If yes, specify the patient's BMI before starting	cal activity for chronic weight management? Yes No	_			
Is the Cor	If yes, specify the diet and, if no, indicate why ne patient engaging in an increased level of physi If no, indicate why: ne patient currently taking a GLP-1 agonist or other If yes, specify the patient's BMI before starting morbidities (check all that apply):	cal activity for chronic weight management? Yes No				
Is the Cor	If yes, specify the diet and, if no, indicate why ne patient engaging in an increased level of physi If no, indicate why: ne patient currently taking a GLP-1 agonist or othe If yes, specify the patient's BMI before starting morbidities (check all that apply): None	cal activity for chronic weight management? Yes No	_			
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Is the Cor	If yes, specify the diet and, if no, indicate why ne patient engaging in an increased level of physi If no, indicate why: If no, indicate why: If yes, specify the patient's BMI before starting More Heart disease Dyslipidemia	cal activity for chronic weight management? Yes No				

3	SPECIALTY DRUG INFORMATI	ON	
	-	ID Number:	
	mail address of patient or of legal g	uardian if patient is underage:	
3C	Renewal Request		
Plea	ase provide information on the ev	volution of the disease to evaluate the resp	onse to treatment.
Da	ite of initial evaluation (pretreatmen	t): Date of	f most recent evaluation:(mm/dd/yyyy)
	Measures	Result at initial evaluation (pretreatment	t) Result at most recent evaluation
	Weight:	🗆 lbs 🗆 kg	
	Height (in cm):	cm	cm
	ВМІ:	kg/m²	kg/m²
3D	Additional Information	many weeks the patient has been on that dos	e: weeks





First Name:	Last Name:	Permit Number:
Specialty:		
Clinic Name:		
Address:		Suite:
City:	Province:	Postal Code:
E-mail:	Telephone:	Fax:
Signature:		Date:
		(mm/dd/yyyy)

Residents of All Other Provinces
PO BOX 220, MONCTON (NB) E1C 8L3
TEL.: 1-800-667-4511 FAX: 1-844-661-2640

No.