BLUE CROSS®

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

CANNABIS FOR MEDICAL PURPOSES PRIOR AUTHORIZATION REQUEST

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.

- 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.
- Requests for coverage will only be considered for members of benefit plans where Cannabis for Medical Purposes has been included as an eligible Extended Health Care benefit.
- Requests for coverage will only be considered for fresh/dried cannabis flower or cannabis oil, and only when other second / third line treatments have been tried and failed.
- Prior Authorization may be limited to a specified time period and/or annual dollar maximum. Cannabis for Medical Purposes must be obtained directly through a Health Canada approved Licensed Producer.
- 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 Cannabis for Medical Purposes.
- Prior Authorization coverage is contingent on your continued status as a Blue Cross cardholder or beneficiary.

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CANNABIS FOR MEDICAL PURPOSES PRIOR AUTHORIZATION REQUEST

1 POLICY INFORMATION

Plan Member Name: _____

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

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

2 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: _____
(mm/dd/yyyy)

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

Have you already purchased Cannabis for Medical Purposes? ☐ Yes ☐ No

If yes, please attach your paid-in-full receipt with this request form. If you have already submitted your receipt to Blue Cross, please indicate the date of the oldest receipt.

Date :_____
(mm/dd/yyyy)

Part B – Coordination of Benefits

Do you or any dependants have coverage for Cannabis for Medical Purposes under any other plan or program? ☐ Yes ☐ No
If Yes, complete the following:

Policy Number: _____ Carrier: _____
(If applicable, please attach Explanation of Benefits from prior carrier with complete form.)

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

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, 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:** _____
(mm/dd/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, visit www.medaviebc.ca or call 1-800-667-4511.

3 CANNABIS FOR MEDICAL PURPOSES INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

For Initial Request, please complete Sections 3A and 3B. For Renewals, please complete Sections 3A and 3C

3A Prior Authorization Information – Mandatory

Product Name	Strength	Dosage	Diagnosis
CANNABIS FOR MEDICAL PURPOSES	_____ % THC _____ % CBD	_____grams/day	

Method of administration: _____

This request pertains to which of the following products:
- ☐ Fresh / dried cannabis flower
- ☐ Cannabis oil / oil capsules
- ☐ Other. Specify: _____

3B Initial Request

Requests for coverage will only be considered for fresh/dried cannabis flower or cannabis oil, and only when other second / third line treatments have been tried and failed. Only requests for the medical conditions listed below will be considered, without exception.

Mandatory information

Patient has provided a copy of the Medical Authorization in accordance with ACMPR* requirements : ☐ Yes ☐ No
**Access to Cannabis for Medical Purposes Regulations*

Patient has registered with a Licensed Producer for medical cannabis: ☐ Yes ☐ No
*** ***Patient must be registered with a Health Canada Licensed Producer for medical cannabis. Proof must be submitted with first claim*** ***

Please answer all the questions pertaining to the medical condition for which this treatment is prescribed

1. **Refractory Neuropathic Pain**

Indicate if there has been a reasonable therapeutic trial with at least three (3) of the following:

- Tricyclic antidepressants, gabapentinoids, SNRIs, prescribed medical cannabinoids

Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication

3 CANNABIS FOR MEDICAL PURPOSES INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3B Initial Request (cont'd)

2. **Refractory pain in palliative cancer patient**

Indicate if there has been a reasonable therapeutic trial with at least two (2) of the following:

- Opioids, antidepressants, anticonvulsants, dexamethasone, tizanidine, prescribed medical cannabinoids

Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication

3. **Chemotherapy-induced nausea and vomiting (CINV)**

Expected duration of chemotherapy: _____

CINV is not controlled adequately despite preventative therapy including serotonin receptor antagonist and at least one (1) of the following:

- Dexamethasone, NK1 antagonist, dopamine antagonist, prescribed medical cannabinoids

Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication

4. **Spasticity in Multiple Sclerosis (MS) or Spinal Cord Injury (SCI)**

Indicate if there has been a reasonable therapeutic trial with the following:

- Baclofen, gabapentin, tizanidine, Dantrium / dantrolene, benzodiazepines, botulinum toxin, prescribed medical cannabinoids

Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication

3 CANNABIS FOR MEDICAL PURPOSES INFORMATION

Name of patient: _____ Date of Birth : _____

Policy Number: _____ ID Number: _____

3B Initial Request (cont'd)

5. **Please indicate any additional information pertaining to this request:**

3C Renewal Request

Please provide information on the evolution of the disease to evaluate the response to treatment

Date of initial evaluation (pre-treatment): _____ (mm/dd/yyyy)

Date of most recent evaluation: _____ (mm/dd/yyyy)

1. **Specify the condition for which the continuation of treatment is requested:**

- ☐ Refractory neuropathic pain
- ☐ Refractory pain in palliative cancer patient
- ☐ Chemotherapy-induced nausea and vomiting (CINV)
- ☐ Spasticity in Multiple Sclerosis (MS) or Spinal Cord Injury (SCI)

Provide all the data showing the patient has experienced a positive therapeutic response to treatment:

2. **Please indicate any additional information pertaining to this request**

4 PHYSICIAN STATEMENT

Physician Name: _____ Specialty: _____

Telephone Number: _____ Fax Number: _____

Physician Signature: _____ Date: _____ (mm/dd/yyyy)