MEDAVIE BLUE CROSS™

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 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.

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

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1 PHARMACY 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, Number: _____ ☐ Telephone, Number: _____

Name of Program/Pharmacy: _____

Contact Name: _____ Contact E-mail: _____

2 PATIENT INFORMATION

Part A

Patient Name: _____ Date of Birth: _____ (mm/dd/yyyy)

E-mail address of patient (or of legal guardian if patient is underage): _____

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 already submitted your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt. Date: _____ (mm/dd/yyyy)

Part B – Coordination of Benefits

Do you or any dependant 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 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: _____ (mm/dd)

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

If No, please indicate why: _____

Part C – Authorization

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at **www.medaviebc.ca.**

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at www.medaviebc.ca or call 1-800-667-4511.

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

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3 CANNABIS FOR MEDICAL PURPOSES INFORMATION

Name of patient: _____ Date of Birth : _____ (mm/dd/yyyy)

Policy Number: _____ ID Number: _____

E-mail address of patient or of legal guardian if patient is underage: _____

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
- ☐ Edibles
- ☐ 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 : _____ (mm/dd/yyyy)

Policy Number: _____ ID Number: _____

E-mail address of patient or of legal guardian if patient is underage: _____

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 : _____ (mm/dd/yyyy)

Policy Number: _____ ID Number: _____

E-mail address of patient or of legal guardian if patient is underage: _____

3B Initial Request (cont'd)

5. **Pediatric Epilepsy**

Diagnosis: ☐ Dravet Syndrome ☐ Lennox-Gastaut Syndrome

Is the treatment prescribed or in consultation with a neurologist? ☐ Yes ☐ No

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

- Clobazam, Divalproex, Levetiracetam, Rufinamide, Topiramate, Valproate

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

Has patient shown drug resistance epilepsy (increase or persistency in seizure frequency while taking antiepileptic drugs continuously for at least 4 weeks)? ☐ Yes ☐ No

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

3 CANNABIS FOR MEDICAL PURPOSES INFORMATION

Name of patient: _____ Date of Birth: _____ (mm/dd/yyyy)

Policy Number: _____ ID Number: _____

E-mail address of patient or of legal guardian if patient is underage: _____

3C Renewal Request

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

Date of initial evaluation (pretreatment): _____ (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)
- ☐ Pediatric Epilepsy

Is the treatment prescribed or in consultation with a neurologist? ☐ Yes ☐ No

Positive therapeutic response (reduced frequency of seizures): ☐ Yes ☐ No

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**

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HEALTH PROFESSIONAL STATEMENT

I certify that I have reviewed all pages of this request and that all information provided is true, correct and complete.

First Name: _____ Last Name: _____ Permit Number: _____

Specialty: _____

Clinic Name: _____

Address: _____ Suite: _____

City: _____ Province: _____ Postal Code: _____

E-mail: _____ Telephone: _____ Fax: _____

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

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit.

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