CS SPECIAL AUTHORIZATION REQUEST FORM

Fax Requests to **905-949-3029**
OR Mail Requests to **Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2**
OR Email S.Authorization@Claimsecure.com
INCOMPLETE FORM MAY RESULT IN DELAYS OR A DENIAL

1. TO BE COMPLETED BY PATIENT

Plan Member Name	Group Number	Certificate Number

Patient Name	Relationship to Member: ☐Self ☐Spouse ☐Other

Street Address	City

Province	Postal Code	Telephone Number	Patient Date of Birth (YYYY/MM/DD)
		( )	

If you would like to receive your response letter via email, please type your email address to ensure accuracy, otherwise, we will reply by mail.

Email Address

OR If you are registered with eProfile and would like your response letter sent to you by email, please check "yes" below and we will use the email you provided for your eProfile account.

☐ **Yes, please email the response/letter to the email I provided in my eProfile account**
☐ **No, I do not wish to receive an email response at this time.**

I hereby authorize any **licensed** physician, **healthcare provider**, hospital, clinic, **medically related facility**, insurance company, patient assistance program administration company and ClaimSecure to exchange **personal** information relating to my health and this Special Authorization request for the evaluation of the eligibility for this drug, adjudication of claims and to ensure continuity of care. I understand that personal information is needed for the above purposes and that refusing to consent may result in delay or denial of my request. I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada. I certify that the information given is true, correct, and complete to the best of my knowledge. I assume responsibility for any cost required for the completion of this form. A photocopy or facsimile of this Form shall be as valid as the original.

Signature **X**	**Date (YYYY/MM/DD)**

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Product Name	Strength

SPOUSAL COVERAGE

If you are a spouse and have your own primary drug coverage, please complete the following:

- **How is the requested drug covered under your primary drug plan?**
  ☐ GENERAL BENEFIT ☐ Requires SPECIAL or PRIOR AUTHORIZATION ☐ EXCLUDED (not covered)
- **IF the requested drug requires SPECIAL or PRIOR AUTHORIZATION under your primary plan, have you requested it?**
  ☐ YES ☐ NO
- **If YES, was the request approved: ☐ YES ☐ NO ☐ PENDING**

PROVINCIAL COVERAGE

Your drug may also be eligible for coverage under the BC Pharmacare Special Authority program. If you have requested Special Authority from BC Pharmacare for this drug, please complete the following:

- **Have you applied for BC PharmaCare Special Authority coverage? ☐ YES ☐ NO**
- **If YES, has your request for Special Authority been approved by BC PharmaCare? ☐ YES ☐ NO ☐ PENDING**

NOTE: ClaimSecure Special Authorization drugs do NOT require BC Pharmacare approval before they will be eligible under your plan.

PATIENT ASSISTANCE PROGRAM

Are you registered with a patient assistance program for your requested drug? ☐ YES or ☐ NO
If yes, please provide:

a) **Case/File #:**_____
b) **Case worker contact information - Name:** _____ **Telephone:** _____

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PRESCRIBING PHYSICIAN INFORMATION

Physician Name	Specialty Qualification	Date (YYYY/MM/DD)

Street Address				
City	**Province**	**Postal Code**	**Telephone Number**	**Fax Number**
			( )	( )

IMPORTANT: IF THE PRESCRIBING PHYSICIAN IS A SPECIALIST, PART 2 BELOW MAY NOT BE REQUIRED. PLEASE REFER TO YOUR BENEFIT PLAN WEBSITE FOR FURTHER INFORMATION.

2. TO BE COMPLETED BY PRESCRIBING PHYSICIAN (IF APPLICABLE)

Drug Requested for Special Authorization	Strength	Regimen
Diagnosis	**Date of Diagnosis**	**Expected Duration of Therapy**
Physical Signature **x**		**Date (YYYY/MM/DD)**

PREVIOUS DRUGS AND THERAPIES FOR CONDITION/DIAGNOSIS

Product Name	Strength	Regimen
Reason for Discontinuation		**Duration of Therapy**
Product Name	**Strength**	**Regimen**
Reason for Discontinuation		**Duration of Therapy**

SITE OF ADMINISTRATION (IF APPLICABLE)

☐ **HOME** ☐ **DOCTOR'S OFFICE** ☐ **PRIVATE CLINIC** ☐ **HOSPITAL** ☐ **LTC FACILITY**

CLINICAL INFORMATION

☐ ECOG_____
☐ WHO Functional Class_____
☐ Patient's Weight_____
KUVAN: Initial Phe levels _____

Initial Request: Responsive to 30 day trial of Phe-restrictive diet ☐ Yes or ☐ No
For Renewal of Kuvan: Maintained Phe-restrictive diet during treatment ☐ Yes or ☐ No
Current Phe levels_____

PLEASE PROVIDE FURTHER DETAILS BELOW AND ATTACH SUPORTING DOCUMENTATION WHERE APPLICABLE