FORM FOR DRUGS APPROVED BY BC PHARMACARE

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 IN PROCESSING SA APPROVAL

IMPORTANT: THIS FORM IS FOR DRUGS APPROVED BY BC PHARMACARE FOR SPECIAL AUTHORITY COVERAGE. IF YOU HAVE NOT ALREADY DONE SO, PLEASE HAVE YOUR DOCTOR REQUEST SPECIAL AUTHORITY APPROVAL FROM BC PHARMACARE, PRIOR TO SUBMITTING THIS FORM.

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 confirmation 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 confirmation 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 confirmation letter to the email I provided in my eProfile account**
☐ **No, I do not wish to receive my confirmation letter via email 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 in determining the eligibility for the requested 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)

SPOUSAL COVERAGE

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

Is the requested drug covered by your primary drug plan? ☐ **Yes or** ☐ **No**

SPECIAL AUTHORITY DOCUMENTATION

Please be advised that your doctor is required to apply to BC PharmaCare and Special Authority must be granted before the requested drug will be covered under your plan. **Please include a copy of your BC Pharmacare Special Authority approval letter with this form.**

Please confirm the following:
☐ **YES**, I have included a copy of the Special Authority approval letter with this form.

☐ **NO**, I have not included written confirmation of Special Authority Approval, however my doctor/pharmacist has confirmed the drug is approved.
(Note: ClaimSecure will call your pharmacy to confirm Special Authority approval)

PRESCRIBING PHYSICIAN INFORMATION

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

Street Address

City	Province	Postal Code	Telephone Number	Fax Number
			( )	( )

DRUG REQUESTED and APPROVED BY PHARMACRE SPECIAL AUTHORITY

Product Name	Strength