SPECIAL AUTHORIZATION REQUEST
For Erectile Dysfunction

Fax Requests to 905-949-3029

OR Mail Requests to Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2

TO BE COMPLETED BY PATIENT (forms without a certificate # will delay processing)

Plan Member	Group Number	Certificate Number (10 Digits)

Patient Name	Relationship to Member ☐Self ☐Spouse ☐Other	Street Address

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

I hereby authorize any physician, hospital, insurance company, other healthcare professional and ClaimSecure to exchange information in connection with this claim for the purpose of special authorization/patient exception evaluation, adjudication of claims, and administration of my health benefit program. I assume responsibility for any cost required for the completion of this form. A photocopy of this authorization shall be as valid as the original.

Signature X	Date (YYYY/MM/DD)

TO BE COMPLETED BY PHYSICIAN ONLY (please print clearly)

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

Street Address	Physician Signature X

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

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Product Name	Strength

PLEASE SUBMIT A COPY OF YOUR PHARMACY MEDICATION CLAIMS HISTORY FROM LAST YEAR

Patient suffers from erectile dysfunction, the consistent inability to obtain and maintain an erection satisfactory for sexual intercourse, due to:

☐ **Patient suffers a side effect to the current use of necessary prescription drugs. Please specify the drug(s):**

☐ **Patient suffers from diabetes mellitus AND is on insulin and/or medication**

☐ **Patient suffers from aorta-iliac disease with evidence of decreased blood flow (e.g. abnormal Doppler studies or absent pulses)** (Attach Test Results)

☐ **Patient had post radical prostatectomy and radiation of the prostate**

☐ **Patient suffers from neurological injury or disease (e.g. multiple sclerosis, spinal cord injury)**

☐ **Patient has documented endocrine abnormalities (e.g. low testosterone levels)** (Attach Test Results)

☐ **Patient suffers from a psychiatric disorder for which he is receiving medication or treatment from a psychiatrist**

☐ **Patient has other medical condition(s) causing erectile dysfunction:**

In addition to the above, has the patient received a prescription for any form of nitrates in the past 6 months?
☐ Yes ☐ No

If yes, please outline the circumstances below.

INCOMPLETE FORMS WILL DELAY PROCESSING

INTERNAL USE ONLY

Approved ☐Yes ☐No	Effective Date (YYYY/MM/DD)	Expiry Date (YYYY/MM/DD)	Reviewer