



SPECIAL AUTHORIZATION REQUEST
Standard Form

Fax Requests to 905-949-3029
OR Email Special.Authorization@Claimsecure.com
OR Mail Requests to
INCOMPLETE FORM MAY RESULT IN DELAYS OR A DENIAL

TO BE COMPLETED BY PATIENT

Plan Member, Group Number, Certificate Number, Patient Name, Relationship to Member, Street Address, City, Province, Postal Code, Telephone Number, Patient Date of Birth

If you would like a 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.

(Please be advised, all response/letters that are emailed will not be followed up by a mailed response.)

I hereby authorize:
1. 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.
2. ClaimSecure to exchange personal information with the above parties and service providers, including case management program and/or preferred pharmacy network (PPN) partners, working with ClaimSecure for the administration of my health benefit program, and where applicable, the administration of the case management program and pharmacy preferred provider network on my behalf.

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 of this authorization shall be as valid as the original.

Signature, Date (YYYY/MM/DD)

SPOUSAL COVERAGE

If you are a spouse applying for Special Authorization and have your own primary drug coverage, please be advised that you must first inquire about coverage of the requested drug with your primary drug plan.

How is the requested drug covered under your primary drug plan?
GENERAL BENEFIT, Require SPECIAL or PRIOR AUTHORIZATION, EXCLUDED

If your primary drug plan requires you to apply for Special or Prior Authorization for the requested drug, please answer the following:
Have you applied for coverage through Special or Prior Authorization? YES or NO
What is the coverage decision for the requested drug? APPROVED or DECLINED

Please provide documents.

PROVINCIAL COVERAGE (TO BE COMPLETED BY PLAN MEMBER)

Please be advised that some medications may be covered under the provincial plans. If your drug is listed on the formulary it is important that you and your physician apply for coverage under the provincial plan first to avoid delays in your Special Authorization request.

Have you applied for provincial coverage? YES or NO
Has your request been approved? YES or NO

Please provide documents.



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PATIENT ASSISTANT PROGRAM (TO BE COMPLETED BY PLAN MEMBER)

Are you registered with a patient assistant program for your prescribed medication? YES or NO
If yes, please provide:
a) Case/File #: _____
b) Case worker contact information - Name: _____ Telephone: _____

TO BE COMPLETED BY PHYSICIAN

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

NEW REQUEST RENEWAL DOSE INCREASE OTHER

Product Name	Strength	Regimen
Diagnosis		Expected Duration of Therapy

PREVIOUS DRUG 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 SUPPORTING DOCUMENTATION WHERE APPLICABLE

