claimsecure

SPECIAL AUTHORIZATION REQUEST
Standard Form

Fax Requests to **905-949-3029**
OR Email Special.Authorization@Claimsecure.com
OR Mail Requests to AIR CANADA / CLAIMSECURE INC. **PO BOX 7878 SUDBURY ON P3E 0A9**
INCOMPLETE FORM MAY RESULT IN DELAYS OR A DENIAL

TO BE COMPLETED BY PATIENT

Plan Member	Group Number	Certificate Number
ANGELA ADDOLORATA ZAMPINI	002152	2152099700

Patient Name

Relationship to Member: ☐ Self ☐ Spouse ☐ Other

Street Address	City
5645 RUE JOSEPH-DUFRESNE	MONTREAL-NORD

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

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)
X	2021-01-18

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