EXPRESS SCRIPTS®

Request For Prior Authorization

Complete and Submit Your Request

Any plan member who is prescribed a medication that requires prior authorization needs to complete and submit this form. Any fees for the completion of this form are the responsibility of the patient.

3 Easy Steps

STEP 1	Plan Member completes Section 1.
STEP 2	Prescribing doctor completes Section 2.
STEP 3	Fax or mail the completed form to Express Scripts Canada®.

Fax:
Express Scripts Canada Clinical Services
(905) 712-6329

Mail:
Express Scripts Canada Clinical Services
2915 Argentia Road, Unit 7 Mississauga,
ON L5N 8G6

Approval Process

Completion and submission of this form is not a guarantee of approval. Plan members will receive reimbursement for the prior authorization drug through their private drug benefit plan only if the request has been reviewed and approved by Express Scripts Canada.

The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based medicine.

Please note that you have the right to appeal the decision made by Express Scripts Canada.

Notification

The plan member will be notified whether their request has been approved or denied. The decision will also be communicated to the prescribing doctor by fax, if requested.

Please continue to page 2.

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Section 1 – Plan Member

Please complete this section and then take the form to your doctor for completion.

First Name:	Last Name:
Date of Birth (DD/MM/YYYY): / /	Gender: ◯ Male ◯ Female
Address:	
City:	Province: Please select one
Postal Code:	Telephone:
Insurance Carrier:	
Group #:	Client ID:
Relationship: ◯ Cardholder/Plan Member ◯ Spouse ◯ Dependant	

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

Please continue to page 3.

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Section 2 – Prescribing Doctor

Drugs in the Prior Authorization Program may be eligible for reimbursement only if the patient does not qualify for reimbursement under a provincial plan and if the patient uses the drug(s) for Health Canada approved indication(s).

Please provide information on your patient's medical condition and drug history, as required by the group benefit provider to reimburse this medication.

Please note: All information requested below is mandatory for the approval process, any fields left blank will result in an automatic rejection. Please fill any non-applicable fields with 'N/A'. Supplemental information for this drug reimbursement request will be accepted.

Please check the appropriate box: ◯ First time Prior Authorization application ◯ Prior Authorization Renewal
Medication brand name and chemical name:
Indication/Medical condition:
The stage/severity/type of the patient's medical condition:
Any additional information relevant to the patient's medical condition and treatment (for example, lab values, symptoms, genetic tests, health status assessments, BMI):
Drug dosage and administration, duration of treatment (Include frequency and number of cycles if for cancer treatment):
Concurrent therapy or therapies for the same treating condition (both pharmacological and non-pharmacological):

Please continue to page 4.

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Indicate name(s) of previously tried therapies:	Inadequate/Suboptimal Response	Allergy/Drug Intolerance
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

Regarding the site of drug administration, please indicate:

The type of setting (ex: home, hospital, private clinic): _____

The name of healthcare facility/hospital/clinic: _____

If this medication is to be administered in a hospital, please check below if the patient will be treated as:

◯ Inpatient ◯ Outpatient

Has the patient applied for reimbursement under a provincial plan?

◯ Yes. Which provincial program was the application made to? _____

◯ No. Why not? _____

What was the outcome? ◯ Approved ◯ Denied

Additional Comments/Notes:

Physician's Name:	Specialty:
Address:	
Tel:	Fax:
License No.:	
Doctor Signature:	Date:
Do you want to be informed of the decision?	◯ Yes, by fax ◯ No