claimsecure

# SPECIAL AUTHORIZATION REQUEST

Fax Requests to 905-949-3029

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

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

| Member Name | Group Number | Certificate Number (10 Digits) |
|---|---|---|
| | | |

| Patient Name | Relationship to Member | Address |
|---|---|---|
| | ☐Member ☐Spouse ☐Child ☐Other | |

| 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 | Date (YYYY/MM/DD) |
|---|---|
| X | |

## TO BE COMPLETED BY PHYSICIAN ONLY (PLEASE PRINT CLEARLY)

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

| Address | Physician Signature |
|---|---|
| | X |

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

## DRUG REQUESTED FOR SPECIAL AUTHORIZATION (1 FORM PER DRUG)

| Drug Name | Strength | Sig |
|---|---|---|
| | | |

| Diagnosis | Duration of Therapy |
|---|---|
| | |

## PREVIOUS DRUGS PRESCRIBED FOR THIS CONDITION (IF APPLICABLE)

| Drug Name | Strength | Sig |
|---|---|---|
| | | |

| Reason for Discontinuation | Duration of Therapy |
|---|---|
| | |

| Drug Name | Strength | Sig |
|---|---|---|
| | | |

| Reason for Discontinuation | Duration of Therapy |
|---|---|
| | |

REASON FOR PRESCRIBING REQUESTED DRUG:

☐ No other therapeutic alternative for patient's medical condition
☐ Prior therapy used was not effective: _____
☐ Could not tolerate prior therapy / side effects: _____
☐ Other

**(Please provide explanation below, or on the back of the form, to expand on checked item(s). Attach supporting documentation where applicable.)**

RELEVANT MEDICAL INFORMATION (IF APPLICABLE):

☐ VIRAL GENOTYPE_____ ☐ EDSS RATING_____ ☐ WHO FUNCTIONAL CLASS_____
☐ BASDAI/BASFI SCORE_____ ☐ HAQ DISABILITY INDEX_____ ☐ ECOG PERFORMANCE STATUS_____
LAB RESULTS:_____

SITE OF DRUG ADMINISTRATION (IF APPLICABLE):

☐ Home ☐ Doctor's Office ☐ Private Clinic ☐ Hospital Clinic ☐ Hospital ☐ LTC Facility

**INCOMPLETE FORMS WILL DELAY PROCESSING**