DRUG SPECIAL AUTHORIZATION REQUEST FORM, PREFERRED PHARMACY NETWORK, AND ADHERENCE SUPPORT PROGRAM INFORMATION

COMPLETING YOUR FORM…

To ensure prompt processing of your request, please complete the following Special Authorization Request Form in full. Note that there are sections that must be completed by you, the patient, and sections that must be completed by **your prescriber**. Once completed, submit the form to Green Shield Canada (GSC) via your method of choice:

By email: drugspecial.autho@greenshield.ca

By fax: 1.866.797.6483

By mail: Green Shield Canada, Drug Special Authorization Department
P.O. Box 1606, Windsor ON N9A 6W1

Note that submission of an incomplete form may result in delays.

Your request will be reviewed and evaluated by our Drug Special Authorization Department who will share the results with you. Should you have any questions, call GSC's Contact Centre at 1.888.711.1119.

OTHER DRUG COVERAGE...

If you are eligible for coverage by another plan (public or private), indicate that on the authorization form.

If you have provincial drug coverage, please ensure that your prescriber has applied for coverage under your primary provincial drug plan. The result of that application must be attached to the completed Special Authorization Request Form.

PREFERRED PHARMACY NETWORK (PPN)

If your request for coverage is approved, you may be required to obtain your special authorization drug at an approved pharmacy. If this applies to your benefits plan, a care coordinator working on behalf of GSC will contact you to help you find an approved pharmacy near you. The care coordinator will also work with you and your physician to arrange to have your prescription sent to the pharmacy you select.

Should you choose not to speak with the care coordinator, and you obtain your special authorization drug at an unapproved pharmacy, your claim may not be paid under your benefits plan.

ADHERENCE SUPPORT PROGRAM

Some drug treatment plans are complicated, and patients can sometimes find it difficult to follow their prescriber's instructions when taking their medication. If your special authorization drug is approved, you may be eligible for adherence support services. A medication management specialist can work with you to ensure that you have the support necessary to take your medication as instructed and adhere to your drug treatment plan.

PRESCRIPTION DRUG
SPECIAL AUTHORIZATION REQUEST FORM

Please note: Incomplete and/or missing information may delay your request for processing.

SECTION 1 – PATIENT INFORMATION

Surname	Green Shield I.D. #	Employer Name
First Name	Date of Birth (Y/M/D)	Telephone Number
Street Address	City Province Postal Code	

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, clinic or medically related facility, to provide to Green Shield Canada information regarding my health as it relates to this request.

I hereby authorize Green Shield Canada to obtain and exchange personal information with other parties as required, including any health care provider, patient assistance program and/or preferred pharmacy network (PPN) vendor working with Green Shield Canada for the purpose of administering this benefit. I acknowledge that my personal information is needed to assess eligibility for this drug, to administer the group benefits plan, and where applicable, to administer pharmacy preferred provider network and patient support programs on my behalf. I acknowledge that my personal information may be exchanged and transferred between these parties for these purposes and may include information about my prescription drug claims, diagnosis, medical condition, treatment, and other health related information. I acknowledge that providing my consent will help Green Shield Canada to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instructions to that effect at the address indicated below.

I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada only when the information is needed to administer this benefit and/or to confirm the accuracy of this information.

I certify that the information given is true, correct, and complete to the best of my knowledge.

Date_____ **Signature of Patient** _____

(If under 16 years of age, the signature of the parent / guardian is required.)

SECTION 2 – PRESCRIBER INFORMATION

Prescriber Name	Prescriber Signature	Specialty	Date (Y/M/D)
Street Address		Telephone Number	
City Province Postal Code		Fax Number	

SECTION 3 – DRUG REQUESTED FOR EVALUATION

Product Name/Strength/Dose/Duration of Treatment:	Diagnosis:

Injectable-location of administration (CHECK ONE):

- HOME
- PHYSICIAN'S OFFICE
- HOSPITAL (IN-PATIENT)
- HOSPITAL (OUT-PATIENT)
- LONG TERM CARE FACILITY

Previous Therapeutic History for above condition (Please include relevant lab results):	Contact Information:

Product name/dose/duration and results of prior treatment:

_____

_____

_____

Additional comments pertaining to medication/medical condition:

Please provide us with information on other coverage (provincial or private) as it pertains to this patient and medication:

Applied for coverage: ☐ Yes ☐ No ☐ Approved ☐ Denied

SECTION 4 – PATIENT ASSISTANCE PROGRAM / ALTERNATIVE DRUG ACCESS NAVIGATOR

Is your patient enrolled in a patient assistance program? ☐ Yes ☐ No If Yes, name of program(s): _____

Patient assistance program I.D. number: _____

Patient assistance program contact information: Contact name:_____ Phone Number: (___) _____

Has your patient been in contact with an alternative drug access navigator (eg.hospital)? ☐ Yes ☐ No

Alternative drug access navigator contact information : Contact name_____ Phone number (____) _____

SECTION 5 – MAILING INSTRUCTIONS

Once completed, return request form along with any original paid "Official Pharmacy" receipts to: **Green Shield Canada, Drug Special Authorization Department, P.O. Box 1606, Windsor ON N9A 6W1**

Forms can be faxed or emailed: Fax: 1-519-739-6483 or Toll Free: 1-866-797-6483 or Email: drugspecial.autho@greenshield.ca

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.

DAPAGLIFLOZIN (FORXIGA®) ELIGIBLE CRITERIA

Please present this Eligible Criteria sheet to your prescriber to use as reference when completing the Special Authorization Request.

ELIGIBLE CRITERIA

For use as an adjunct to diet, exercise, and other antihyperglycemic agents to improve glycemic control in adult patients with type 2 diabetes mellitus when diet and exercise plus maximal tolerated dose of metformin do not achieve adequate glycemic control.

OR

For use in the treatment of heart failure with reduced ejection fraction after failure with an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) AND a beta blocker.

OR

For use in combination with an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) in adult patients with chronic kidney disease with an eGFR of 25 - 75 ml/min/1.73 m2 to reduce the risk of sustained eGFR decline, end-stage kidney disease, and cardiovascular and renal death.

These drugs may have the potential for other uses outside of the indications identified, but are only eligible benefits of the controlled formularies under the conditions specified and with the proper documentation.

Veuillez présenter cette feuille des critères admissibles à votre prescripteur qu'il utilisera comme document de référence lorsqu'il remplira la Demande d'autorisation spéciale.

CRITÈRES ADMISSIBLES

Utilisation comme traitement d'appoint à un régime alimentaire, à l'exercice et à d'autres antihyperglycémiants pour améliorer l'équilibre glycémique chez les patients adultes atteints de diabète sucré de type 2 dont le diabète n'est pas maîtrisé de façon adéquate par le régime alimentaire et l'exercice ainsi que par la dose maximale tolérée de metformine.

OU

Pour le traitement de l'insuffisance cardiaque à fraction d'éjection réduite en concomitance avec un inhibiteur de l'enzyme de conversion de l'angiotensine (IECA) ou un antagoniste des récepteurs de l'angiotensine (ARA) ET un bêta-bloquant.

OU

Pour utilisation en association avec un inhibiteur de l'enzyme de conversion de l'angiotensine (ECA) ou un antagoniste des récepteurs de l'angiotensine (ARA) chez les patients adultes atteints de néphropathie chronique dont le taux de filtration glomérulaire estimé (TFGe) est de 25 à 75 mL/min/1,73 m^2 pour réduire le risque de diminution soutenue du TFGe, de néphropathie terminale et de décès d'origine cardiovasculaire ou rénale.

Ces médicaments pourraient être employés pour d'autres usages que les indications identifiées, mais ils ne sont que des prestations admissibles des formulaires contrôlés en vertu des conditions précisées et lorsqu'ils sont accompagnés par les documents pertinents.