

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
<p>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.</p> <p>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.</p> <p>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.</p> <p>I certify that the information given is true, correct, and complete to the best of my knowledge.</p>			
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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Approved <input type="checkbox"/> Denied			
SECTION 4 – PATIENT ASSISTANCE PROGRAM / ALTERNATIVE DRUG ACCESS NAVIGATOR			
Is your patient enrolled in a patient assistance program? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

FESOTERODINE FUMARATE (TOVIAZ®) ELIGIBLE CRITERIA

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

ELIGIBLE CRITERIA

**For patients with urinary frequency, urgency, or urge incontinence who have:
Failed to respond to behavioral techniques AND
An adequate trial of oxybutynin with gradual dose escalation has shown to be either ineffective or resulted in unacceptable side effects.**

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.

Veillez 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

**Pour les personnes souffrant de pollakiurie (fréquence urinaire), de mictions impérieuses ou d'incontinence par impériosité:
chez qui les techniques comportementales n'ont pas réussi ET
un essai adéquat d'oxybutynine avec dose graduelle a démontré qu'il n'était pas efficace ou qui a produit des effets secondaires inacceptables.**

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.