

Prior Authorization Request

[Instructions](#)

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

3 Easy Steps

Step 1 – Plan Member completes Part A.

Step 2 – Prescribing doctor completes Part B.

Step 3 – Fax or mail the completed form to Express Scripts Canada®.

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada
Clinical Services
1-855-712-6329

Mail: Express Scripts Canada
Clinical Services
6985 Financial Drive, Suite 300
Mississauga, ON, L5N 0G3

[Review Process](#)

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

Drugs in the Prior Authorization Program may be eligible for reimbursement if the plan member does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply.

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 clinical protocols.

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.

Prior Authorization Request

Part A – Plan Member

Please complete Part A and have your physician complete Part B.

Plan member information

First Name:		Last Name:	
Insurance Carrier Name/Number:			
Group Number:		Client ID:	
Date of Birth (YYYY/MM/DD):		Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French		Gender: ☐ Male ☐ Female	
Address:			
City:	Province:	Postal Code:	
Email address:			
Telephone (home):	Telephone (cell):	Telephone (work):	

Coordination of benefits

Patient Assistance Program	Is the plan member enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the plan member applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied *Attach decision letter*
Primary Coverage	Has the plan member applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied *Attach decision letter*

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. This service uses AI-enabled Optical Character Recognition (OCR) technology provided by a third-party vendor to process submitted documents; all Prior Authorization related decisions are made by a human. To exercise your rights of access or rectification, please contact ExpressScriptsCanada_Privacy@Express-scripts.com.

 Plan Member Signature

 Date

Prior Authorization Request

Part B – Prescriber

Drugs in the Prior Authorization Program may be eligible for reimbursement only if the patient uses the drug(s) for Health Canada approved indication(s). Drugs used for indications not approved by Health Canada may be denied. For Quebec patients, RAMQ exception drug criteria may apply. Please provide information on your patient's medical condition and drug history, as required by the group benefit provider to reimburse this medication. Incomplete forms may result in automatic denial. Please fill any non-applicable fields with 'N/A'. Supplemental information for this drug reimbursement request will be accepted.

- | | |
|--------------------------|--|
| ☐ | First time Prior Authorization application for this drug *Fill sections 1, 2 and 4* |
| ☐ | Prior Authorization Renewal for this drug *Fill sections 1,3 and 4* |

SECTION 1 – DRUG REQUESTED

Drug Name:			
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration
Medical Condition:			
Will this drug be used according to its Health Canada approved indication(s) ? ☐ Yes ☐ No			
Site of drug administration:			
☐ Home	☐ Physician's office/Infusion clinic	☐ Hospital (outpatient)	☐ Hospital (inpatient)

SECTION 2 – FIRST-TIME APPLICATION

Please provide any relevant information on the patient's condition including the severity/stage/type of condition Example: monthly frequency and duration for migraines, fibrosis status for Hepatitis C patient, lab values such as LDL and IgE levels, BMI, symptoms etc. <i>(please do not provide genetic test information or results)</i>
Therapies (pharmacological/non-pharmacological) that will be used for treating the same condition concomitantly:

SECTION 2 – FIRST-TIME APPLICATION (continued)

Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – RENEWAL INFORMATION

Date of treatment initiation:

Details on clinical response to the requested drug

Example: PASI/BASDAI, laboratory tests, etc. *(please do **not** provide genetic test information or results)**If prior approval was not authorized by Express Script Canada, please attach a copy of the approval letter.***SECTION 4 – PRESCRIBER INFORMATION**

Physician's Name:

Address:

Tel:

Fax:

License No.:

Specialty:

Physician Signature:

Date: