



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 <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Address	
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 X		Date (YYYY/MM/DD)
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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