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 ☐Member ☐Spouse ☐Child ☐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	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