PRESCRIPTION DRUG SPECIAL AUTHORIZATION, PHARMACY PPN, AND ADHERENCE SUPPORT PROGRAM INFORMATION

Dear Patient:

Form Completion Instructions

Please have the following Special Authorization Request Form completed in full by <u>your physician</u>. If you are eligible for coverage by another plan (public or private) please have your physician indicate that in the authorization form. Your request will be reviewed and evaluated by our Drug Special Authorization Department who will communicate the results to you. Should you have any questions, you may contact our Customer Contact Centre at 1.888.711.1119.

Provincial Drug Coverage

For those patients eligible for provincial drug coverage (including, but not limited to Ontario Drug Benefit, British Columbia Pharmacare, Saskatchewan Special Support Program, Alberta Prescription Drug Program for Seniors, etc.): **Your primary drug coverage is your provincial drug program.** Please ensure that your physician has applied for such drug approval under your primary provincial drug plan. The result of this application for coverage to your primary provincial drug plan should be attached to the completed authorization form.

Preferred Pharmacy Network (PPN)

Depending on your benefit plan, you may be required to obtain your special authorization drug at an approved pharmacy if your claim is approved. If this applies to your benefit plan, a Care Coordinator working on behalf of Green Shield Canada[1] 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 forwarded to the pharmacy you have selected. By completing this form, you authorize Green Shield Canada to, where applicable, communicate your choice of approved pharmacy to your physician. Should you choose not to speak with the Care Coordinator and obtain your special authorization drug at an approved pharmacy, your claim may not be paid under your benefit plan.

Adherence Support Program

Some drug treatment plans are complicated and patients can find it difficult to follow their physician's instructions when taking their medication. If your special authorization drug is approved, you may be eligible for adherence support services as part of the PPN program. Your Care Coordinator can work with you and your physician to ensure that you adhere to your drug treatment plan by helping you take your medication as instructed by your physician.

[1] The Care Coordinator who will be contacting you works for Health Forward who has been contracted by Green Shield Canada to provide PPN services.

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 – PHYSICIAN INFORMATION

Physician Name	Physician 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

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: (___) _____

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 (e.g. FORXIGA®)
ELIGIBLE CRITERIA

Please present this Eligible Criteria sheet to your physician 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 and at least one other concurrent antihyperglycemic agent do not achieve adequate glycemic control.

Consideration will be given for contraindications or intolerances to required previous therapy

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.

Note to Pharmacist:

For electronic billing please ensure that the physician's medical information corresponds with the eligible criteria. If unclear, please forward form to Green Shield Canada – Drug Special Authorizations. If assessed at pharmacy, please retain the Drug Special Authorization form (in store), provided the medication is dispensed on a regular basis. If treatment is discontinued, form must be retained for a period of two years for audit purposes.

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

CRITÈRES ADMISSIBLES

Pour l'utilisation comme un adjuvant à l'alimentation, à l'exercice et aux autres agents antihyperglycémiques pour améliorer la maîtrise de la glycémie chez les patients adultes atteints de diabète de type 2 lorsque l'alimentation et l'exercice ainsi que la dose maximale tolérée de metformine et au moins un autre agent antihyperglycémique concomitant ne réalisent pas la maîtrise adéquate de la glycémie.

Les contre-indications ou intolérances à une précédente thérapie requise seront prises en consideration.

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.

Note au(à la) pharmacien(ne) :

En ce qui concerne la facturation électronique, veuillez vous assurer que les renseignements médicaux du médecin correspondent aux critères d'admissibilité. S'il n'est pas clair, veuillez envoyer le formulaire à Green Shield Canada – Autorisations spéciales pour médicaments. S'il est évalué à la pharmacie, veuillez garder le formulaire d'Autorisation spéciale pour médicaments (en magasin) sous réserve que le médicament soit délivré sur une base régulière. Si le traitement est interrompu, le formulaire doit être gardé pendant une période de deux ans à des fins de vérification.