MANITOBA BLUE CROSS®

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST

MEMBER INFORMATION

Certificate Number	Client Number	
Last Name	First Name	
Address		
City	Province	Postal Code
Email Address / Phone Number		

COORDINATOR INFORMATION*

***Section to be filled out by the professional coordinating the request on behalf of the service recipient (Patient Support Program, Physician or Pharmacist)**	
Program/Pharmacy Name	
Contact Name	
Contact Phone Number	Fax Number
Communication Preference Fax ☐ Mail ☐ Email ☐ _____	

SERVICE RECIPIENT (PATIENT) INFORMATION

Is the service recipient also the member? Yes ☐ No ☐ Current address the same as above? Yes ☐ No ☐ If no, please fill in the section below:			
Service Recipient Last Name	Service Recipient First Name		
Address	City	Province	Postal Code
Does the service recipient have valid provincial health care coverage in current province of residence? Yes ☐ No ☐			

COORDINATION OF BENEFITS INFORMATION

Is the service recipient covered under any other plan for this drug? Yes ☐ No ☐ If yes, please fill in the section below:			
Carrier	Policyholder	Policy Number	Effective Date (dd/mm/yyyy)
Carrier	Policyholder	Policy Number	Effective Date (dd/mm/yyyy)
Has the service recipient applied for coverage through Pharmacare or another publicly funded program? Yes ☐ No ☐			
If yes, program name:			
If no, please explain why:			

CONSENT AND AUTHORIZATION

☐ I hearby authorize any health care provider to release to Manitoba Blue Cross any medical information about myself and my dependents which relations to claims submitted by us or on our behalf to Manitoba Blue Cross.

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.

Service Recipient/Member Signature: _____ Date: _____

SEE REVERSE FOR SPECIALTY DRUG DETAILS AND PHYSICIAN STATEMENT

PATIENT SUPPORT PROGRAM (PSP) ENROLLMENT

Is service recipient in a manufacturer patient support program? Yes ☐ No ☐	
Program Name	Program Number
Phone Number	Fax Number

SPECIALTY DRUG DETAILS

List the details about the specialty drug(s) prescribed to the service recipient:

Product	Strength	Dosage	Frequency	Diagnosis
Product	Strength	Dosage	Frequency	Diagnosis

Service recipient weight: lbs ☐ kgs ☐

Expected duration of therapy: Was treatment initiated in a hospital? Yes ☐ No ☐

What other treatments have been tried/ what were the results? Please provide any lab data or scores that would support the diagnosis and severity of the disease (If necessary, please attach additional pages or documentation):

Please indicate any additional information that you feel would be beneficial to assist our clinical team in reviewing this request: (If necessary, please attach additional pages or documentation):

PHYSICIANSTATEMENT

Physician Name	Specialty
Clinic Name	Clinic Address
Phone Number	Fax Number

Physician Signature: _____ Date: _____

HOW TO SUBMIT A SPECIALTY DRUG AUTHORIZATION REQUEST

email: pharmacyservices@mb.bluecross.ca

Fax: 1.204.772.1231

Mail: PO Box 1046 Stn Main
Winnipeg, MB R3C 2X7

In Person/Drop Box: 599 Empress Street
Winnipeg, MB