claimsecure

SPECIAL AUTHORIZATION REQUEST
Standard Form

Fax Requests to **905-949-3029**
OR Mail Requests to **ClaimSecure Inc. P.O. Box 6500 Station A, Sudbury, Ontario, P3A 5N5**
OR Email Special.Authorization@Claimsecure.com
INCOMPLETE FORM MAY RESULT IN DELAYS OR A DENIAL

TO BE COMPLETED BY PATIENT

Plan Member	Group Number	Certificate Number

Patient Name	Relationship to Member: ☐Self ☐Spouse ☐Other

Street Address	City

Province	Postal Code	Telephone Number	Patient Date of Birth (YYYY/MM/DD)
		( )	

If you would like a response/letter via email, please type your email address to ensure accuracy, otherwise, we will reply by mail.

Email Address

OR If you are registered with eProfile and would like your response/letter sent to you by email, please check "yes" below and we will use the email you provided for your eProfile account.

☐ **Yes, please email the response/letter to the email I provided in my eProfile account**
☐ **No, I do not wish to receive an email response at this time.**

All responses/letters that are emailed will not be followed up by a mailed response.

PLEASE NOTE: Some drugs may be excluded from coverage or may be excluded when prescribed for specific conditions. If you have any questions regarding drug coverage, please contact our Customer Response Centre at 1-888-513-4464.

PRIVACY CONSENT

Protecting your personal information:
At ClaimSecure, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information:
Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to evaluate your eligibility for products, price our products collect feedback on our customer service, process claims, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. Your certificate number is used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with:
We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, and other organizations that provide us services such as paramedical examiners, medical laboratories, specialty coverage providers, independent medical examiners, and pharmacies. As well, we may share your information with travel assistance providers, technology suppliers, and insurance or reinsurance companies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information:
We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by submitting a request to our Privacy Office at privacy@claimsecure.com . This includes choosing whether you receive customer experience surveys, and whether you want to receive information and offers from ClaimSecure using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights, such as access to or correction of your personal information, by emailing our Privacy Office at privacy@claimsecure.com.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

ClaimSecure uses personal information when making decisions related to products and services. These decisions may be made using automated processing.

Want to learn more? Please visit https://www.claimsecure.com/privacy-policy/.

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AUTHORIZATIONS AND DECLARATIONS

I hereby:

1. **Authorize ClaimSecure, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient support programs or other benefits programs, other organizations, or service providers working with ClaimSecure or any of the foregoing, located inside or outside Canada, to exchange personal information when relevant and necessary for the evaluation of the eligibility for this drug, adjudication of claims and to ensure continuity of care.**
2. **Acknowledge that my personal information will be collected, used and shared as set out above; and that refusing to consent may result in delay or denial of my request.**
3. **Acknowledge that ClaimSecure reserves the right to audit the information provided on this form at any time for purposes that include preventing and detecting fraud and this consent extends to any audit of my claim(s).**
4. **I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose the information provided on this form to my benefit plan sponsor/employer for the purposes of reporting instances of fraud, waste or abuse suspected by ClaimSecure.**
5. **Confirm that, where the patient is a person other than myself, the patient has given their consent to provide their personal information and for ClaimSecure to use and disclose it as set out above.**
6. **Confirm that the information given is true, correct, and complete to the best of my knowledge. Failure to provide true, correct, and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.**
7. **Acknowledge that I am responsible for any cost required for the completion of this form.**

Signature (Patient/Member Signature) X	**Date (YYYY/MM/DD)**

SPOUSAL COVERAGE

If you are a spouse applying for Special Authorization and have your own primary drug coverage, please be advised that you must first inquire about coverage of the requested drug with your primary drug plan.

How is the requested drug covered under your primary drug plan?
☐ **GENERAL BENEFIT** ☐ **Require SPECIAL or PRIOR AUTHORIZATION** ☐ **EXCLUDED**

If your primary drug plan requires you to apply for Special or Prior Authorization for the requested drug, please answer the following:
Have you applied for coverage through Special or Prior Authorization? ☐ **YES or** ☐ **NO**
What is the coverage decision for the requested drug? ☐ **APPROVED or** ☐ **DECLINED**

Please provide documents.

PROVINCIAL COVERAGE (TO BE COMPLETED BY PLAN MEMBER)

Please be advised that some medications may be covered under the provincial plans. If your drug is listed on the formulary it is important that you and your physician apply for coverage under the provincial plan first to avoid delays in your Special Authorization request.

Have you applied for provincial coverage? ☐ **YES or** ☐ **NO**
Has your request been approved? ☐ **YES or** ☐ **NO**

Please provide documents.

PATIENT ASSISTANT PROGRAM (TO BE COMPLETED BY PLAN MEMBER)

Are you registered with a patient assistant program for your prescribed medication? ☐ **YES or** ☐ **NO**
If yes, please provide:

a) **Case/File #:** _____
b) **Case worker contact information - Name:** _____ **Telephone:** _____

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TO BE COMPLETED BY PHYSICIAN

Physician Name	Specialty Qualification	Date (YYYY/MM/DD)

Street Address	Physician Signature X

City	Province	Postal Code	Telephone Number	Fax Number
			( )	( )

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

☐ NEW REQUEST ☐ RENEWAL ☐ DOSE INCREASE ☐ OTHER

Product Name	Strength	Regimen

Diagnosis	Expected Duration of Therapy

PREVIOUS DRUG AND THERAPIES FOR CONDITION/DIAGNOSIS

Product Name	Strength	Regimen

Reason for Discontinuation	Duration of Therapy

Product Name	Strength	Regimen

Reason for Discontinuation	Duration of Therapy

SITE OF ADMINISTRATION (IF APPLICABLE)

☐ HOME ☐ DOCTOR'S OFFICE ☐ PRIVATE CLINIC ☐ HOSPITAL ☐ LTC FACILITY

CLINICAL INFORMATION

☐ ECOG_____

☐ WHO Functional Class_____

☐ Patient's Weight_____

KUVAN: Initial Phe levels _____ **Initial Request:** Responsive to 30 day trial of Phe-restrictive diet ☐ **YES or** ☐ **NO**

For Renewal of Kuvan: Maintained Phe-restrictive diet during treatment ☐ **YES or** ☐ **NO**

PLEASE PROVIDE FURTHER DETAILS BELOW AND ATTACH SUPPORTING DOCUMENTATION WHERE APPLICABLE

Clear