

PO BOX 220, MONCTON (NB) E1C 8L3 TEL.: 1-800-667-4511 FAX: 1-844-661-2640 PO BOX 3300, STATION B, MONTREAL (QC) H3B 4Y5 TEL.: 1-888-873-9200 FAX: 1-514-286-8480

CANNABIS FOR MEDICAL PURPOSES PRIOR AUTHORIZATION REQUEST

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PROCEDURES FOR PRIOR AUTHORIZATION

Completed forms can be faxed in confidence to 1-514-286-8480 for residents of Quebec and 1-844-661-2640 for residents of all other provinces

Upon receipt, this request will be confidentially reviewed according to payment criteria developed by Blue Cross in consultation with independent health care consultants. In some cases, additional clinical and/or diagnostic information may be required in order to process your claim.

- Prior Authorization is a pre-approval process to determine if certain products will be reimbursed under a member's benefit plan.
- Please complete entire form. Incomplete forms cannot be processed.
- Requests for coverage will only be considered for members of benefit plans where Cannabis for Medical Purposes has been included as an eligible Extended Health Care benefit.
- Requests for coverage will only be considered for fresh/dried cannabis flower or cannabis oil, and only when other second / third line treatments have been tried and failed.
- Prior Authorization may be limited to a specified time period and/or annual dollar maximum.
 Cannabis for Medical Purposes must be obtained directly through a Health Canada approved Licensed Producer.
- In cases where a request for Prior Authorization is declined, Blue Cross is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.
- Any costs associated with the completion of this form or obtainment of additional medical information are the responsibility of the member.
- Renewal of the Prior Authorization will be considered by Blue Cross upon request from the patient/member. The renewal request should include information from the physician supporting continued use of Cannabis for Medical Purposes.
- Prior Authorization coverage is contingent on your continued status as a Blue Cross cardholder or beneficiary.





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CANNABIS FOR MEDICAL PURPOSES PRIOR AUTHORIZATION REQUEST

1 POLICY INFORMATION					
Plan Member Name:					
Address:	City:	Province:			
Telephone Number:	Policy Number:	ID Number:			
2 PATIENT INFORMATION					
Part A					
Is Patient also the Plan Member? $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	es 🗌 No 🔲 Current address sa	ame as above (if not, please comp	lete applicable fields below)		
Patient Name (if not plan member):					
Address:	City:	Province:	Postal Code:		
Telephone Number:	ID Number:	Date of Birth:	(mm/dd/yyyy)		
Do you have valid Medicare coverage in Have you already purchased Cannabis	·	Yes □ No	(ппластуууу)		
If yes, please attach your paid-in-full retthe date of the oldest receipt.	ceipt with this request form. If you ha	ave already submitted your receipt	to Blue Cross, please indicate		
Date :					
Part B – Coordination of Benefits					
Do you or any dependants have coverage if Yes, complete the following:	•				
Policy Number:(If applicable, please at	Carrier:				
If the patient is a dependent, provide the					
in the patient is a dependent, provide the	solitil day and month of the cardnor	(dd/mm)	_		
Part C – Authorization					
I hereby authorize any health care publich relates to claims submitted by			ut myself and my dependents		
I understand that the personal informatic Blue Cross and/or Blue Cross Life Insur the group policy of which I am an eli business. Depending on the type of confidence third parties include other Blue Control regulatory authorities, the member of an the benefits outlined in the policy of which	ance Company of Canada, may be gible member, to recommend suite overage I carry, limited personal in Cross organizations, health care proposed under which I am a participation.	collected, used, or disclosed to ad- able products and services to me formation may be collected from ofessionals or institutions, life and	minister the terms of my policy or e, and to manage Blue Cross's and/or released to a third party. health insurers, government and		
I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.					
I authorize Blue Cross to collect, use an	d disclose my personal information	as described above.			
Signature of Patient:		Date:	(mm/dd/yyyy)		
A photocopy of this authorization shall be as privacy policies at Blue Cross, visit					



3 CANNABIS FOR MEDICAL PURPOSES Name of patient:			Date of Birth :				
-	Date of Birth :						
For Initial Request, please complete Sections 3A and 3B. For Renewals, please complete Sections 3A and 3C							
BA Prior Authorization Information – Mano Product Name	datory Strength	Dosage	Diagnosis				
Floude Name	% THC	Dosage	Diagnosis				
CANNABIS FOR MEDICAL PURPOSES	% CBD	grams/day					
Method of administration:							
This request pertains to which of the following	☐ Cannab	dried cannabis flower ois oil / oil capsules Specify:					
BB Initial Request	ered for fresh/dried can	nabis flower or cannabis	s oil. and only when other second / third li				
Requests for coverage will only be conside reatments have been tried and failed. Only Mandatory information	requests for the medic	cal conditions listed belo	w will be considered, without exception.				
Requests for coverage will only be conside reatments have been tried and failed. Only	requests for the medic	cal conditions listed belo	w will be considered, without exception.				
Requests for coverage will only be considereatments have been tried and failed. Only Mandatory information Patient has provided a copy of the Medical	al Authorization in accord	cal conditions listed belo dance with ACMPR* requir	www.ill be considered, without exception.				
Requests for coverage will only be considereatments have been tried and failed. Only Mandatory information Patient has provided a copy of the Medica *Access to Cannabis for Medical Purposes Repaired with a Licensed Pr	al Authorization in accord gulations roducer for medical cann	dance with ACMPR* requirely reached below the second transfer of the	ew will be considered, without exception. The ements: Yes No The coof must be submitted with first claim ***				
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Requests for coverage will only be considereatments have been tried and failed. Only Mandatory information Patient has provided a copy of the Medica *Access to Cannabis for Medical Purposes Repaired has registered with a Licensed Provided a copy of the Medica *Access to Cannabis for Medical Purposes Repaired has registered with a Licensed Provided Health Provide	al Authorization in according all Authorization in according at a condition and a condition for the medical condition in according to the medical condition for the medical co	dance with ACMPR* require tables: Yes No cer for medical cannabis. Provided the statement is presented the statement of the following dist three (3) of the following discal cannabinoids	rements: Yes No rements be submitted with first claim *** rescribed				
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3 CANNABIS F	FOR MEDICAL PURPOSES INI	FORMATION							
				Date of Birth :					
Policy Number:	olicy Number: ID Number:								
B Initial Reque	st (cont'd)								
2. Refractory	pain in palliative cancer patier	nt							
Indicate if ther	e has been a reasonable therap	eutic trial with at I	east two (2) of the following	g:					
- Opioids, ant	- Opioids, antidepressants, anticonvulsants, dexamethasone, tizanidine, prescribed medical cannabinoids								
0-1	Donald and Name	D	Dt'ana af Tarastra ant	Decreased to Transfer and an Ocales in the street					
Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication					
		_							
		_							
		+							
3. Chemother	apy-induced nausea and vomi	iting (CINV)							
o. Onemotilen	apy madeed madeed and voin	illig (Oliv)							
Expected dura	ation of chemotherapy:								
	ontrolled adequately despite pre-	ventative therapy	including serotonin receptor	antagonist and at least one (1) of the					
following:									
- Dexamethas	sone, NK1 antagonist, dopamine	antagonist, preso	cribed medical cannabinoids						
Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication					
4. Spasticity in	n Multiple Sclerosis (MS) or S	pinal Cord Injury	(SCI)						
Indianta if the	e has been a reasonable therap	acutio trial with the	following						
	•		•						
- Baclofen, gabapentin, tizanidine, Dantrium / dantrolene, benzodiazepines, botulinum toxin, prescribed medical cannabinoids									
Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication					
									

3	3 CANNABIS FOR MEDICAL PURPOSES INFORMATION			
Na	Name of patient:	Date of Birth :		
Po	Policy Number: ID Number:	<u> </u>		
3B	3B Initial Request (cont'd)			
5.	5. Please indicate any additional information pertaining to this request:			
	3 to 1 to			
3C	3C Renewal Request			
Ple	Please provide information on the evolution of the disease to evaluate the response to treatmen	t		
Da	Date of initial evaluation (pre-treatment): Date of most recent evaluation (mm/dd/yyyy)	uation:		
	(mm/dd/yyyy)	(mm/dd/yyyy)		
1.	1. Specify the condition for which the continuation of treatment is requested:			
	☐ Refractory neuropathic pain			
	☐ Refractory pain in palliative cancer patient			
	☐ Chemotherapy-induced nausea and vomiting (CINV)			
	☐ Spasticity in Multiple Sclerosis (MS) or Spinal Cord Injury (SCI)			
2.	Provide all the data showing the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to treatment of the patient has experienced a positive therapeutic response to the patient has experienced a positive therapeutic response to the patient has experienced a positive therapeutic response to the patient has experienced a positive therapeutic response to the patient has experienced a positive therapeutic response to the patient has experienced and the patien	ent:		
Te	Physician Name: Specialty: Fax Number: Fax Number:			
۲ħ	Physician Signature: D.	ate:(mm/dd/yyyy)		