IUOE Local 793

Pension and Benefits Administered by

# Medical Prior Authorization For Exception Drugs or Limited Use Drugs

## A Introduction

Plan Members need this form to initiate a pre-authorization process for the IUOE Local 793 Plan to review and consider the coverage of limited use drugs. Special Evaluation drugs may not be covered at 100% because there is a therapeutic alternative OR it is not included on our standard formulary and is currently only covered at a lower percentage. This request requires that the health care provider completes this form and gives medical reasons including other medications tried in the past for this condition/disease and any additional information relevant to the request.

Please note that only the Indications published in the Product Monograph submitted to Health Canada will be considered.

➔ Expenses incurred by the completion of this form are at the Plan Member's expense.

➔ If the patient has another drug plan, this prior authorization may cover some or all the excess not paid for by that plan.

Please request, fill in, and return an updated Personal Information File (PIF) to notify OEBAC of any changes in information about: **(a)** you, the Plan Member; **(b)** your dependants; **(c)** any other health care plan that you or your dependants may have; **(d)** your beneficiaries; **(e)** your bank accounts; or **(f)** the individuals authorized to inquire about your benefits. By doing this on time, you will facilitate faster processing of your claims and reduce the chances of claim rejection.

## B Plan Member's information

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ABCDEFGH

| Full Name | | From your OEBAC Benefits Card<br>Group #: ☐ 793 ☐ 793X<br>Certificate #:<br>Or, from your IUOE Local 793 Card<br>Registration #: |
|---|---|---|
| Phone # | Email | |

| Patient's Name | | Results of this request to be communicated to:<br>☐ Pharmacy<br>☐ Patient / Legal guardian named below<br>☐ Email: |
|---|---|---|
| Phone # | | |
| Name of Patient or Legal Guardian | Signature of Patient or Legal Guardian | Date (yyyy-mm-dd) |

| Other Group Benefit coverage<br>☐ Yes ☐ No | If "Yes", Name of family member covered:<br>Name of Insurance Company:<br>Plan #: Plan member ID #: |
|---|---|
| Provincial Coverage<br>☐ Yes ☐ No | If "Yes" please complete the following and attach documentation with decision to accept or decline<br>If "No" explain the reason that application has not been made: |

| Patient Support Program<br>☐ Yes ☐ No | Name of program: | Patient Assistance ID #: |
|---|---|---|

| Support program Case Worker | Phone # |
|---|---|
| Email | Fax # |

By signing below,

- I solemnly declare that the information provided on this form is accurate to the best of my knowledge.
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use and disclose the provided information and any other information collected about me, my Dependants, or my Beneficiaries to process my benefits, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans.

| Name of the Plan Member | Signature of the Plan Member | Date (yyyy-mm-dd) |
|---|---|---|
| | | |

## C To be completed by Prescribing Physician

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| Drug Name | DIN |
|---|---|
| Concentration | Dosage |

| Diagnosis | Expected duration of treatment (yyyy-mm-dd)<br>From: To: |
|---|---|

To be administered at:

☐ Patient’s home, or in a community health centre (CLSC) or physician’s office
☐ Hospital, long-term care facility, public residential facility, or private institution under agreement (including outpatient consultations)
☐ Other (please specify)

Please indicate what other medications the Patient has tried and the adverse effects.

Other relevant medical information:

| Physician’s Name | Licence # | Telephone # | Fax Number |
|---|---|---|---|
| Address | Town/City | Province | Postal Code |

| Name of Physician | Signature of Physician | Date (yyyy-mm-dd) |
|---|---|---|
| | | |

## C To be completed by Pharmacist

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| Pharmacy Name | Provider Number | Telephone Number | Fax Number |
|---|---|---|---|
| | | | |
| Pharmacy Address | Town/City | Province | Postal Code |
| | | | |

| Name of Pharmacist | Signature of Pharmacist | Date (yyyy-mm-dd) |
|---|---|---|
| | | |

Staple this form and all the attachments and mail them to

**OEBAC**
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to
**info@oebac.org**