MANITOBA BLUE CROSS®

PO BOX 1046 Winnipeg MB R3C 2X7
FAX: 1.866.706.5835

CINUP

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST

SEE REVERSE FOR APPLICATION PROCEDURES

Please complete **entire** form. If information is missing from the form, it will be returned to the member. Incomplete forms cannot be processed. **Any costs associated with the completion of this form or obtaining additional medical information are the responsibility of the patient/member.**

PATIENT INFORMATION (To be completed by the Patient/Member)

Member Name	Certificate Number		Policy Number
Patient Name	Date of Birth (DD/MM/YYYY)	Telephone Number ( )	
Street Address	City	Province	Postal Code

Have you already purchased your prescription ? ❑ Yes ❑ No If Yes, please attach your paid-in-full receipt.

I hereby authorize any health care provider to release to Manitoba Blue Cross, any medical information about myself and my dependents which relates 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 and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me*, and to manage Blue Cross' 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 organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the 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, in some instances doing so may prevent Manitoba 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 Manitoba Blue Cross to collect, use and disclose my personal information as described above.

Signature of Patient (parent/guardian): ____________________ Date: ____________________
(If under 18 years of age the signature of the member is required.)

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information on privacy policies at Manitoba Blue Cross, visit www.mb.bluecross.ca or call 1-800-873-2583.

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Product Name	Strength	Dosage	Quantity	Diagnosis

Expected duration of therapy __________ For injectables, facility where medication is administered ____________________

❑ No previous treatment ❑ Previous treatment

Results from previous treatment		Relevant Lab Test Results
❑ Successful	❑ Patient did not tolerate	
❑ Failed	❑ Contraindication	

Please note: This is not a request to have procedures completed, but to provide results if they have previously been completed.

Additional information relating to request:

PHYSICIAN / NURSE PRACTITIONER INFORMATION

Physician / Nurse Please Print)	Telephone Number ( )		Fax Number ( )
Street Address	City	Province	Postal Code
Prescriber's Signature			

Forward the completed information to Manitoba Blue Cross, PO Box 1046, Winnipeg, Manitoba R3C 2X7 or Fax 1.866.706.5835

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*†Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association.

PROCEDURES FOR SPECIAL AUTHORIZATION

- Special Authorization is a pre-approval process to determine if certain products will be reimbursed under your benefit plan.
- Eligible prescriptions must be purchased at a Manitoba Blue Cross approved provider.
- Special authorization coverage is contingent on your continued status as a Manitoba Blue Cross member or beneficiary.
- If your plan is based on reimbursement, submit your original paid-in-full receipt to Manitoba Blue Cross to be considered for reimbursement.

This form must be completed by your attending physician and forwarded to:

Private and Confidential
Manitoba Blue Cross
Special Authorization - Prescription Drugs
PO Box 1046
Winnipeg, Manitoba R3C 2X7
or
FAX: 1.866.706.5835

Upon receipt, the request will be confidentially reviewed according to payment criteria developed by Manitoba Blue Cross in consultation with independent health care consultants. In some cases, additional diagnostic or clinical information may be required.

Special Authorization may be limited to a specified time period and/or quantity of medication. Renewal of the Special Authorization will be considered by Manitoba Blue Cross upon request from the patient/member. The renewal request should include information from the physician supporting continued use of the medication.

If the information on your form is complete, the usual turnaround time for assessment is five (5) working days. You will receive written notification regarding the decision. In cases where you require an urgent response due to a medical condition, every effort will be made to respond within one business day. If you wish to have a response faxed back to you, request this in writing on your special Authorization form.

NOTE TO PHYSICIAN

Under the Special Authorization program, Manitoba Blue Cross grants approval for payment of certain benefits if they fall within certain established criteria. By denying a request for Special Authorization, Manitoba Blue Cross is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.