MHCSI
Managed Health Care Services Inc.

Please send completed forms to MHCSI:
Fax: 1-902-481-7114 **E-Mail:** professionalservices@mhcsi.ca
Mail: 1-535 Portland Street, Dartmouth, NS B2Y 4B1

MHCSI PRIOR AUTHORIZATION FORM – GENERAL (INITIAL/RENEWAL REQUEST)

Strictly confidential. This form must be completed in **FULL** and submitted to MHCSI to permit authorization for coverage of a prior authorization medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met and this class of medication is a benefit of your plan. Please contact MHCSI for details of the criteria for these medications. Approvals may be subject to quantity or dollar limits as per plan design.

TO BE COMPLETED BY EMPLOYEE - PATIENT INFORMATION

Member Name:	Group #	Certificate or Client ID #
Mailing Address:	City:	
Province:	Postal Code:	Phone # ( )
Patient Name:	Date of Birth: (DD/MM/YYYY)	

Do you or any dependents have other coverage under any other plan ☐ No ☐ Yes **(If Yes, complete the following)**

Name of other Insurer:_____ Member Name: _____

ID #: _____ Policy #: _____

Is this drug covered by coordinating plan? ☐ No ☐ Yes

Are you enrolled in a manufacturer patient assistance program? ☐ No ☐ Yes (program name)_____

Please note you are enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs; Sobeys Pharmacy; Sobeys Pharmacy by Mail; Safeway Pharmacy; FreshCO Pharmacy; Thrifty Foods Pharmacy Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island. Please indicate your preferred pharmacy location: _____

I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.

Signature (patient 14 yr. and older/parent/legal guardian) **X**	**Date:** (DD/MM/YYYY)

TO BE COMPLETED BY PHYSICIAN – MEDICATION/DIAGNOSTIC INFORMATION FOR ALL REQUESTS

Medication Requested:	Dosage & Interval:	DIN:
Quantity Requested:	For Injectables, facility where medication is administered:	
Diagnosis/Indication:	Anticipated length of therapy:	
Therapeutic Goals:		

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TO BE COMPLETED BY PHYSICIAN – CURRENT CLINICAL INFORMATION INITIAL COVERAGE

MEDICATIONS TRIED	DOSE/FREQUENCY	DURATION	RESPONSE / ADVERSE EVENT / CONTRAINDICATIONS

Results of supporting lab tests/other testing if applicable: _____
_____

Additional supporting clinical information:

Alternative baseline therapies are not an option because?

☐ CONTRAINDICATION ☐ ADVERSE EFFECT ☐ THERAPEUTIC FAILURE ☐ OTHER Please explain:

TO BE COMPLETED BY PHYSICIAN – RENEWAL COVERAGE

Response to therapy: *(please provide details)*

Prescribing Physician: Please note this patient is enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs; Sobeys Pharmacy; Sobeys Pharmacy by Mail; Safeway Pharmacy; FreshCO Pharmacy; Thrifty Foods Pharmacy Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island.

PRESCRIBING PHYSICIAN	DISPENSING PHARMACIST
Name and Mailing Address: Phone: _____ Fax:_____	Name, Store & Contact Information: Phone: _____ Fax:_____

MHCSI OFFICE USE

☐ Approved Extension Possible ☐ Yes ☐ No ☐ Declined DECLINE CODE:_____		**Notes:**
Date:	Ph.C.:	
Approved Date Range:		
Quantity	Processing Number:	
PPN Only: ☐ Yes ☐ No PPN Dispensing Pharmacy Called: ☐ Yes ☐ No		