

MEMBER INFORMATION

Policy Number _____ ID Number _____

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Email Address _____

Phone Number _____

COORDINATOR INFORMATION

To be filled out by the professional coordinating the request on behalf of the patient (Patient Support Program, Physician or Pharmacist)

Program/Pharmacy Name _____

Physician's Name _____

Phone Number _____

Fax Number _____

Communication Preference:
 Fax Phone Email _____

PATIENT INFORMATION

First Name _____ Last Name _____ Relationship to Member _____ Date of Birth (YYYY-MM-DD) _____

Does the patient have healthcare coverage in current province of residence? Yes No

COORDINATION OF BENEFITS INFORMATION

Do you or your dependents have coverage for this drug under any other plan? Yes No

If yes, please complete below.

Name of Insurance Company _____ Policy Number _____

Has the patient applied and/or been approved for special access coverage through a provincial drug plan? Yes — Applied Yes — Approved No
(e.g., Exception Drug Status under the Saskatchewan Drug Plan)

Has the patient applied for cost assistance through a provincial government program? Yes No

If yes, please provide program name below:

Program Name _____

If no, please provide explanation below:

CONSENT & AUTHORIZATION

I authorize my healthcare provider(s) to release any information or records requested in respect of this claim to Blue Cross or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

I understand that the personal information I have provided, as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or its agents may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, claims adjudication and payment, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, and to help develop and recommend suitable products and services to me. 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, and/or its authorized agents/brokers, representatives, licensed physicians and/or any other health care professionals or institutions, life and health insurers and reinsurers, government and regulatory authorities, the member of any benefit plan or policy under which I am a participant and other third parties only when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; 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. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.

Member / Patient Signature _____ Date (YYYY-MM-DD) _____

COMPLETE FORM ON NEXT PAGE FOR SPECIALTY DRUG DETAILS AND PHYSICIAN STATEMENT

PATIENT SUPPORT PROGRAM (PSP) ENROLLMENT

Is the patient in a manufacturer patient support program? Yes No

If yes, please complete the below section:

Program Name	Program Number
Phone Number	Fax Number

SPECIALTY DRUG DETAIL

List the details about the specialty drug prescribed to the patient:

Product: _____ Strength: _____ Dosage: _____

Frequency: _____ Diagnosis: _____

Expected duration of therapy: _____ BMI: _____ kg/m² Weight: _____ lb kg

Is the patient following a reduced calorie diet for the purposes of weight reduction? Yes No

Is the patient engaging in increased physical activity for chronic weight management? Yes No

Comorbidities (check all that apply):

- Arthritis Dyslipidemia Heart Disease Hypertension Obstructive Sleep Apnea Type II Diabetes
 None

Please indicate any additional information that you feel would be beneficial to assist our team in reviewing this request.

PHYSICIAN STATEMENT

Physician's Name (Printed)	Physician's Specialty	
Address		
City	Province	Postal Code
Telephone Number	Fax Number	
Physician's Signature	Date (YYYY-MM-DD)	

HOW TO SUBMIT A SPECIALTY DRUG AUTHORIZATION REQUEST

By email: ProviderRelations@sk.bluecross.ca

By fax: 306-667-5860

By mail: Attn: Claims Department
Saskatchewan Blue Cross
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2