

SPECIAL AUTHORIZATION REQUEST

Fax Requests to 905-949-3029

OR Mail Requests to Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2

PLEASE SUBMIT A COPY O	F YOUR PHA			DIC.	ATION			
Member Name	ember Name		Group Number			Certificate Number (10 Digits)		
Patient Name	Relationship to Member Address			3				
	☐Member ☐Spouse ☐Child ☐Other							
City	Province	Postal Code		1	Telephone	Number	Patient Date of Birth (YYYY/MM/DD)	
					()		
I hereby authorize any physician, hospital, insurance special authorization/patient exception evaluation, ac of this form. A photocopy of this authorization shall	djudication of claims, a	nd administration						
Signature X							Date (YYYY/MM/DD)	
TO BE COMPLETED BY PH	YSICIAN ON	LY (PLE	ASE	PRI	NT CLE	EARLY)		
Physician Name	Specialty Qualification					Date (YYYY/MM/DD)		
Address	L			Physician Signature X				
City	Province	Postal Code			Telephone	Number	Fax Number	
					()	()	
DRUG REQUESTED FOR SPECIAL AUTHORIZATION (1 FORM PER DRUG)								
Drug Name					Strength		Sig	
Diagnosis						Duration of Therapy		
PREVIOUS DRUGS PRESCRIBED FOR THIS CONDITION (IF APPLICABLE)								
Drug Name					Strength		Sig	
Reason for Discontinuation						Duration of Therapy		
Drug Name				Strength	ı	Sig		
Reason for Discontinuation Duration of Therapy								
 No other therapeutic alternative for patier □ Prior therapy used was not effective: □ Could not tolerate prior therapy / side effe □ Other (Please provide explanation below, or applicable.) 	ects:		pand	on ch	ecked iten	n(s). Attach supp	porting documentation where	
RELEVANT MEDICAL INFORMATION (I	· · · · · · · · · · · · · · · · · · ·							
☐ VIRAL GENOTYPE ☐ BASDAI/BASFI SCORE	_ □ EDSS RA	ATING ABILITY IND	FY			HO FUNCTIONAL OG PERFORMAN		
LAB RESULTS:	_ □ HAQ DIS	ADILII I IND	EA		🗆 EC	OG PERFORMANI	CE STATUS	
SITE OF DRUG ADMINISTRATION (IF A								
☐ Home ☐ Doctor's Office	□ Private Clini	с 🗆 Н	ospita	ıl Clini	ic [Hospital	□ LTC Facility	