Benefit Plan Administrators Limited
A member company of the BPA Financial Group Est 1958
BPA
90 Burnhamthorpe Rd. W., Ste. 300, Mississauga, ON, L5B 3C3
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Group Benefit – Brand Drug Plan Prior Authorization

PATIENT IS RESPONSIBLE FOR ANY CHARGE INCURRED FOR THE COMPLETION OF THIS FORM

SECTION 1 - TO BE COMPLETED BY THE PLAN MEMBER AND PATIENT

Plan Sponsor Name: _____Policy# _____

Plan Member Last Name _____ First Name and Initial _____

Plan Member ID _____

Plan Member Address:

_____

No. Street City Province Postal code

Patient Last Name _____ First Name and Initial_____

Relationship to Plan Member_____

Patient's Date of Birth _____(yyyy/mm/dd)

I authorize Benefit Plan Administrators to collect and exchange personal information about me to process this request and administer my group plan. I understand any personal information obtained by Benefit Plan Administrators Limited will be kept confidential and, where necessary, Benefit Plan Administrators Limited will be exchanging my personal information. I authorize the following persons to exchange with Benefit Plan Administrators Limited or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer and insurance broker or plan administrator.

I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Signature of Plan Member _____ Date_____yyyy/mm/dd)

Signature of Patient if over 18 _____ Date_____yyyy/mm/dd)

PATIENT IS RESPONSIBLE FOR ANY CHARGE INCURRED FOR THE COMPLETION OF THIS FORM

SECTION 2 - TO BE COMPLETED BY ATTENDING PHYSICIAN

PLEASE COMPLETE THE FOLLOWING DETAILS ABOUT THE BRAND DRUG THAT REQUIRES AUTHORIZATION TO BE COVERED UNDER THE DRUG BENEFIT PROGRAM.
UNDER THE BRAND DRUG AUTHORIZATION PROCEDURE OF OUR DRUG PLANS, BENEFIT PLAN ADMINISTRATORS LIMITED APPROVES PAYMENT FOR CERTAIN DRUGS IF THEY MEET THE DEFINED CRITERIA FOR THE PRESCRIPTION DRUG USE. BY DECLINING COVERAGE FOR A CERTAIN DRUG, BENEFIT PLAN ADMINISTRATORS LIMITED IS NOT CHALLENGING THE MEDICAL OPINION OF THE PHYSICIAN OR RENDERING A MEDICAL OPINION.

Patient's Name _____ Patient's Date of Birth_____

Physician Last Name_____ First Name and Initial _____

Physician Address _____
No. Street City Province Postal Code

Telephone (_____) ____ - _____Fax Number(____) _____ -_____

1) Drug Name _____DIN _____Strength Quantity _____

2) What is the expected duration of therapy? _____

3) What is the reason for this request?
- ☐ Contraindication
- ☐ Adverse Event
- ☐ Therapeutic Failure
- ☐ Other

4) What is the patient's diagnosis? _____

5) Please provide a description of the previous treatment program and its Results. _____

_____

6) For oral and non-orally administered drugs, where will the drug be administered?
☐ Home (Self Administered) [ ] Hospital (Inpatient or Outpatient)
☐ Private Clinic (Please indicate Name and Street Address)
_____

7) Please provide any additional information that supports the use of this drug for this patient.
_____

I DECLARE that the information in this statement is true to the best of my knowledge.

Signature of Physician (in full) _____ Date _____