



# SPECIAL AUTHORIZATION REQUEST Standard Form

Grandeur

Phone: 1-866-969-7756

OR Mail Requests to Grandeur Group Benefits, 5090 Explorer Drive, Suite 501 Mississauga, Ontario, L4W 4T9

OR Email at [service@grandeurbenefits.com](mailto:service@grandeurbenefits.com)

INCOMPLETE FORM MAY RESULT IN DELAYS OR A DENIAL

| TO BE COMPLETED BY PATIENT  |             |   |                                    |
|---|-------------|---|------------------------------------|
| Plan Member   |             | Group Number  | Certificate Number                 |
| Patient Name  |             | Relationship to Member:<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other |                                    |
| Street Address  |             |   | City                               |
| Province  | Postal Code | Telephone Number<br>(   )   | Patient Date of Birth (YYYY/MM/DD) |
| If you would like a response/letter via email, please type your email address to ensure accuracy, otherwise, we will reply by mail.   |             |   |                                    |
| Email Address   |             |   |                                    |
| OR If you are registered with eProfile and would like your response/letter sent to you by email, please check "yes" below and we will use the email you provided for your eProfile account.<br><input type="checkbox"/> Yes, please email the response/letter to the email I provided in my eProfile account<br><input type="checkbox"/> No, I do not wish to receive an email response at this time.   |             |   |                                    |
| <u>(Please be advised, all response/letters that are emailed will not be followed up by a mailed response.)</u>   |             |   |                                    |
| I hereby authorize:   |             |   |                                    |
| <ol style="list-style-type: none"> <li>Any licensed physician, healthcare provider, hospital, clinic, medically related facility, insurance company, patient assistance program administration company and Grandeur Group Benefits to exchange personal information relating to my health and this Special Authorization request for the evaluation of the eligibility for this drug, adjudication of claims and to ensure continuity of care.</li> <li>Grandeur Group Benefits to exchange personal information with the above parties and service providers, including case management program and/or preferred pharmacy network (PPN) partners, working with Grandeur Group Benefits for the administration of my health benefit program, and where applicable, the administration of the case management program and pharmacy preferred provider network on my behalf.</li> </ol> |             |   |                                    |
| I understand that personal information is needed for the above purposes and that refusing to consent may result in delay or denial of my request.   |             |   |                                    |
| I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada.   |             |   |                                    |
| I certify that the information given is true, correct, and complete to the best of my knowledge. I assume responsibility for any cost required for the completion of this form.   |             |   |                                    |
| A photocopy of this authorization shall be as valid as the original.  |             |   |                                    |
| Signature<br>X  |             |   | Date (YYYY/MM/DD)                  |
| SPOUSAL COVERAGE  |             |   |                                    |
| If you are a spouse applying for Special Authorization and have your own primary drug coverage, please be advised that you must first inquire about coverage of the requested drug with your primary drug plan.   |             |   |                                    |
| How is the requested drug covered under your primary drug plan?<br><input type="checkbox"/> GENERAL BENEFIT <input type="checkbox"/> Require SPECIAL or PRIOR AUTHORIZATION <input type="checkbox"/> EXCLUDED   |             |   |                                    |
| If your primary drug plan requires you to apply for Special or Prior Authorization for the requested drug, please answer the following:<br>Have you applied for coverage through Special or Prior Authorization? <input type="checkbox"/> YES or <input type="checkbox"/> NO<br>What is the coverage decision for the requested drug? <input type="checkbox"/> APPROVED or <input type="checkbox"/> DECLINED  |             |   |                                    |
| Please provide documents.   |             |   |                                    |
| PROVINCIAL COVERAGE (TO BE COMPLETED BY PLAN MEMBER)  |             |   |                                    |
| Please be advised that some medications may be covered under the provincial plans. If your drug is listed on the formulary it is important that you and your physician apply for coverage under the provincial plan first to avoid delays in your Special Authorization request.  |             |   |                                    |
| Have you applied for provincial coverage? <input type="checkbox"/> YES or <input type="checkbox"/> NO<br>Has your request been approved? <input type="checkbox"/> YES or <input type="checkbox"/> NO  |             |   |                                    |
| Please provide documents.   |             |   |                                    |



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GROUP BENEFITS

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## PATIENT ASSISTANT PROGRAM (TO BE COMPLETED BY PLAN MEMBER)

Are you registered with a patient assistant program for your prescribed medication?  YES or  NO  
 If yes, please provide:

a) Case/File #: \_\_\_\_\_  
 b) Case worker contact information - Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

## TO BE COMPLETED BY PHYSICIAN

|                |          |                         |                          |                   |  |
|----------------|----------|-------------------------|--------------------------|-------------------|--|
| Physician Name |          | Specialty Qualification |                          | Date (YYYY/MM/DD) |  |
| Street Address |          |                         | Physician Signature<br>X |                   |  |
| City           | Province | Postal Code             | Telephone Number<br>( )  | Fax Number<br>( ) |  |

## DRUG REQUESTED FOR SPECIAL AUTHORIZATION

NEW REQUEST  RENEWAL  DOSE INCREASE  OTHER

|              |          |                              |
|--------------|----------|------------------------------|
| Product Name | Strength | Regimen                      |
| Diagnosis    |          | Expected Duration of Therapy |

## PREVIOUS DRUG AND THERAPIES FOR CONDITION/DIAGNOSIS

|                            |          |                     |
|----------------------------|----------|---------------------|
| Product Name               | Strength | Regimen             |
| Reason for Discontinuation |          | Duration of Therapy |
| Product Name               | Strength | Regimen             |
| Reason for Discontinuation |          | Duration of Therapy |

## SITE OF ADMINISTRATION (IF APPLICABLE)

HOME  DOCTOR'S OFFICE  PRIVATE CLINIC  HOSPITAL  LTC FACILITY

## CLINICAL INFORMATION

ECOG \_\_\_\_\_  
 WHO Functional Class \_\_\_\_\_  
 Patient's Weight \_\_\_\_\_  
 KUVAN: Initial Phe levels \_\_\_\_\_ Initial Request: Responsive to 30 day trial of Phe-restrictive diet  Yes or  No  
 For Renewal of Kuvan: Maintained Phe-restrictive diet during treatment  Yes or  No  
 Current Phe levels \_\_\_\_\_

## PLEASE PROVIDE FURTHER DETAILS BELOW AND ATTACH SUPPORTING DOCUMENTATION WHERE APPLICABLE

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_