PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

DRUG ELIGIBILITY INQUIRY FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

HOW TO COMPLETE THIS FORM:
MEMBERS — Please complete BLACK portions of this form.
PHYSICIANS — Please complete RED portion of this form.

Incomplete or forms completed by Patient Support Programs will **not** be accepted. Don't forget to sign *Part 2 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for this drug. Coverage is based on the provisions of your Extended Health Care plan.

PART 1 — MEMBER INFORMATION

First name	Last name	Patient's first name (if different than member's name)	Patient's last name

Patient's birthdate (mm-dd-yyyy)	Patient's weight	Patient's height	Daytime phone number (10 digits)	Policy number	ID number

Street address	City	Province	Postal code

PART 2 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your form

I certify that the information contained in this and other documents supporting this claim is complete and true to the best of my knowledge. I certify that all expenses claimed under my EHC plan are medically necessary. I understand that the personal information provided on this claim, as well as any other personal information currently held by Pacific Blue Cross about me and my eligible dependents will be used to determine eligibility for this benefit, assess and pay claims. I hereby acknowledge and agree that the personal information may be exchanged between Pacific Blue Cross and a health care professional, practitioner, institution or health benefits provider, government and regulatory authorities or insurer when needed for a purpose stated above. I understand that the personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered. I understand why the personal information is needed and I am aware of the benefits and risks of consenting or refusing to consent to disclosure. I have read and understand this Member Consent and Declaration.

I authorize my physician to release my personal information to Pacific Blue Cross to obtain Blue RX approval for prescription benefit.

Member's signature X	Date (mm-dd-yyyy)

PART 3 — PHYSICIAN INFORMATION

Physician's name	College ID

Street address	City	Province	Postal code

Phone number (10 digits)	Fax number (10 digits)	Physician's area of specialty

I certify the medical information provided on this form is accurate and current.

Physician's signature X	Date (mm-dd-yyyy)

PART 4 — DRUG REQUEST INFORMATION

Drug name	Strength	Dosage	Duration of therapy

Diagnosis or indication	Year of diagnosis

Not eligible under the BC PharmaCare Special Authority program:*

- ☐ Does not meet PharmaCare* Special Authority criteria (include detailed explanation of why the criteria is not met in *Part 6 — Additional information*)
- ☐ Indication is not eligible under PharmaCare* Special Authority Program
- ☐ Drug is not listed by PharmaCare* (include detailed explanation as to why PharmaCare* benefit drug(s) cannot be tried in *Part 6 — Additional information*)
- ☐ Other (Please use *Part 6 — Additional information* if more space is required): _____

Cancer Therapy — Ensure BCCA* protocol codes for prior and current therapy are included in Part 5 of this form.

- ☐ Attach a copy of the primary article that supports your request

Not eligible for coverage by BC* Cancer Agency:

- ☐ Does not meet BCCA* criteria for coverage (attach copy of the BCCA* denial)
- ☐ Indication is not listed under BCCA* benefit drug list (attach copy of the BCCA* denial)
- ☐ Drug is not listed on the BCCA* benefit drug list
- ☐ Other (Please use *Part 6 — Additional information* if more space is required): _____

Where will the drug be administered?: _____

*** If patient resides outside of BC, please apply to the applicable provincial program.**

Has the patient received any financial assistance or other support related to this drug under a Patient Support Program? ☐ Yes ☐ No
If yes, under which program?:

Please provide any relevant information to the disease and attach supporting documentation if relevant:

PART 5 — DRUGS CURRENTLY OR PREVIOUSLY PRESCRIBED FOR CONDITION

	Name	Strength	Dosage	Duration of therapy (month and year)	BCCA protocol code
Drug 1					
If discontinued, please state reason					
Drug 2					
If discontinued, please state reason					
Drug 3					
If discontinued, please state reason					
Drug 4					
If discontinued, please state reason					
Drug 5					
If discontinued, please state reason					

PART 6 — ADDITIONAL INFORMATION