PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CANADIAN BENEFIT PROVIDERS

Please complete all required sections to allow your request to be processed

PART 1 | CLIENT INFORMATION

PLAN MEMBER NAME (Last Name, First Name)					
GROUP #				MEMBER ID #	
PATIENT NAME (Last Name, First Name)				DATE OF BIRTH (mm/dd/yyyy)	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		EMAIL			

PART 2 | PRESCRIBER INFORMATION

PRESCRIBER NAME (Last Name, First Name)					
STREET ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		FAX			
PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	☐ CPSA ☐ CARNA ☐ ACP ☐ ACO ☐ ADA+C ☐ OTHER			PROFESSIONAL REGISTRATION #	

☐ NEW ☐ RENEWAL | **NOTE: Request may or may not be approved by CBP.**

DRUG(S), DOSAGE(S) AND DURATION REQUESTED. * Please include DIN.
DIAGNOSIS AND/OR INDICATION WHICH DRUG IS BEING USED TO TREAT: (Include applicable information regarding previous medications, patient response to therapy and proposed results of therapy)
ADDITIONAL INFORMATION RELATING TO REQUEST:

PRESCRIBER'S SIGNATURE	DATE (mm/dd/yyyy)

Forward completed form to: Canadian Benefit Providers 301-8925 51 AVE NW EDMONTON AB T6E 5J3 Canada
TEL: (780) 944 9166, FAX: (780) 944 9168, TOLL FREE: (855) 944 9166, EMAIL: helpdesk@cbproviders.ca, www.cbproviders.ca