

PHARMACY PRIOR AUTHORIZATION REQUEST FORM



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	<input type="checkbox"/> CPSA <input type="checkbox"/> CARNA <input type="checkbox"/> ACP <input type="checkbox"/> ACO <input type="checkbox"/> ADA+C <input type="checkbox"/> 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, #202, 10235-124th Street NW, Edmonton, Alberta, T5N 1P9, Canada
 TEL: (780) 944 9166, FAX: (780) 944 9168, TOLL FREE: (855) 944 9166, EMAIL: helpdesk@cbproviders.ca, www.cbproviders.ca