AGA BENEFIT SOLUTIONS

INFORMATION REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

NUTRITIONAL FORMULA

SECTION 1 – INFORMATION ON THE MEMBER

Member name:	Group number:	Certificate number:
Address (No. / Street / Apt.):		
City :	Province :	Postal Code :
Phone number :	E-mail address :	
Employer name / Policy holder: :	Group / Division number:	

SECTION 2 – INFORMATION ON THE PATIENT

Patient name:		
Patient Date of Birth (YYYY/MM/DD):	Relationship to member:	
Have you applied for coverage with a provincial program?	☐ Yes	☐ No
Has your application for coverage with the provincial program for this drug or supply been approved?	☐ Yes	☐ No
If you have applied for coverage with a provincial program, please provide us with a copy of the refusal or acceptance letter.		
Are you enrolled in a drug manufacturer's patient assistance program?	☐ Yes	☐ No
If yes, please provide your patient assistance program identification number : _____		

SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION

I authorize any health professional (doctor, pharmacist, dentist), any person (service provider), any other insurance company, any public or private health institution, any government agency in relation to health or social services, to disclose and exchange requested information by the insurer or AGA Benefits Solutions, necessary for the evaluation of my request for prior authorization for that drug.

Patient signature:	Date:
Signature of the subscriber when patient is a minor:	Date:

SECTION 4 - DRUG COVERED BY THE APPLICATION

Drug Name:			
Dosage:			
Pharmaceutical Form:		Content / Strength:	
Anticipated duration of treatment:	From (YYYY/MM/DD) :	To (YYYY/MM/DD) :	
Diagnosis:		Initial date of diagnosis (YYYY-MM-DD):	

Medication will be administered at the following location:

☐ Home ☐ Health and social service center ☐ Long-term care center ☐ Private clinic

☐ Hospital - internal patient ☐ Hospital - external patient ☐ Elsewhere. Specify : _____

If the treatment is not administered at home, please provide the following information:

Name of the location where the drug will be administered:		Telephone:	
Address (No. / Street / Apt.):	City :	Province:	Postal Code :

SECTION 5 - TYPE OF APPLICATION

☐ Initial request	☐ Continued treatment	☐ Modification of treatment

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SECTION 6- SUMMARY OF PREVIOUS TRIALS OR CONTRAINDICATIONS

Please provide a list of medicines and/or treatments used to date to control this condition:

Name of drug/treatment currently or previously prescribed	Content - strength / Dosage	Trial Period		Reason for Discontinuation
		From (YYYY-MM-DD)	To (YYYY-MM-DD)	
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other. Specify : _____

SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

DIAGNOSIS

☐ Enteral feeding: ☐ Temporary ☐ Permanent

☐ Dietary supplement used for persons suffering from **cystic fibrosis**

☐ Dietary supplement used for **children** suffering from:

- ☐ **Malnutrition** – Specify the cause: _____
- ☐ **Malabsorption** – Specify the cause: _____
- ☐ **Growth failure** – Specify the cause and extent of the failure to thrive: _____

☐ **Total oral feeding** of persons requiring nutritional formulas as their source of nutrition in presence of :

- ☐ **Dysphagia** – Specify the cause: _____
- ☐ **Esophageal dysfunction** – Specify the cause: _____
- ☐ **Maldigestion** – Specify the cause: _____
- ☐ **Malabsorption** – Specify the cause: _____

☐ As **oral feeding** in the **full-term infant** due to:

- ☐ **Allergy to intact milk proteins**
- ☐ **Intolerance to intact milk proteins (persistent diarrhea, severe gastrointestinal disorders)**
- ☐ **Allergies to multiple food proteins**

The initial authorization is up to the age of 12 months. The results of an allergen skin test or of re-exposure to cow's milk proteins must be provided in order for utilization to continue and for any child of 12 months of age and beyond.

☐ As **oral feeding** for **premature infants**:

Weeks of pregnancy: _____

Infant birth weight: _____

Expected date of birth (YYYY/MM/DD): _____

☐ As **oral feeding for infants and children suffering from galactomsemia and requiring a lactose-free diet**

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Dietary Assessment

Percentage of daily caloric intake by taking nutritional formulas: _____ %

Reintroduction of food: ☐ Expected on (YYYY/MM/DD): _____ ☐ Undetermined date

☐ Impossible – Specify: _____

Ingestion can be semi-solid foods that have the same nutritional value as a nutritional supplement containing:

☐ Yes

☐ No - Indicate the reasons that prevent ingestion of semi-solid foods: _____

SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

SECTION 9– ADDITIONAL INFORMATION (optional)

SECTION 10 – SIGNATURE OF AUTHORIZED PRESCRIBER

Print name of authorized prescriber:	Specialty of the physician:	
Signature of authorized prescriber:	License Number:	Date :

SECTION 11 - IMPORTANT PATIENT INFORMATION

Fees may be charged to complete this form, it is the patient's responsibility to pay them.
Ensure all required sections of the form have been completed and signed before returning it.
Attach any additional documents required on this form.
Your request may be delayed if we do not have all the necessary information.
The drug will be eligible only if it meets the criteria established by the insurer.

HOW TO RETURN THE FORM

Submit a claim through the **members portal** Claim type *Prior authorization drugs*	By mail : AGA Benefit Solutions 3500 de Maisonneuve Blvd. W, suite 2200 Westmount (QC) H3Z 3C1