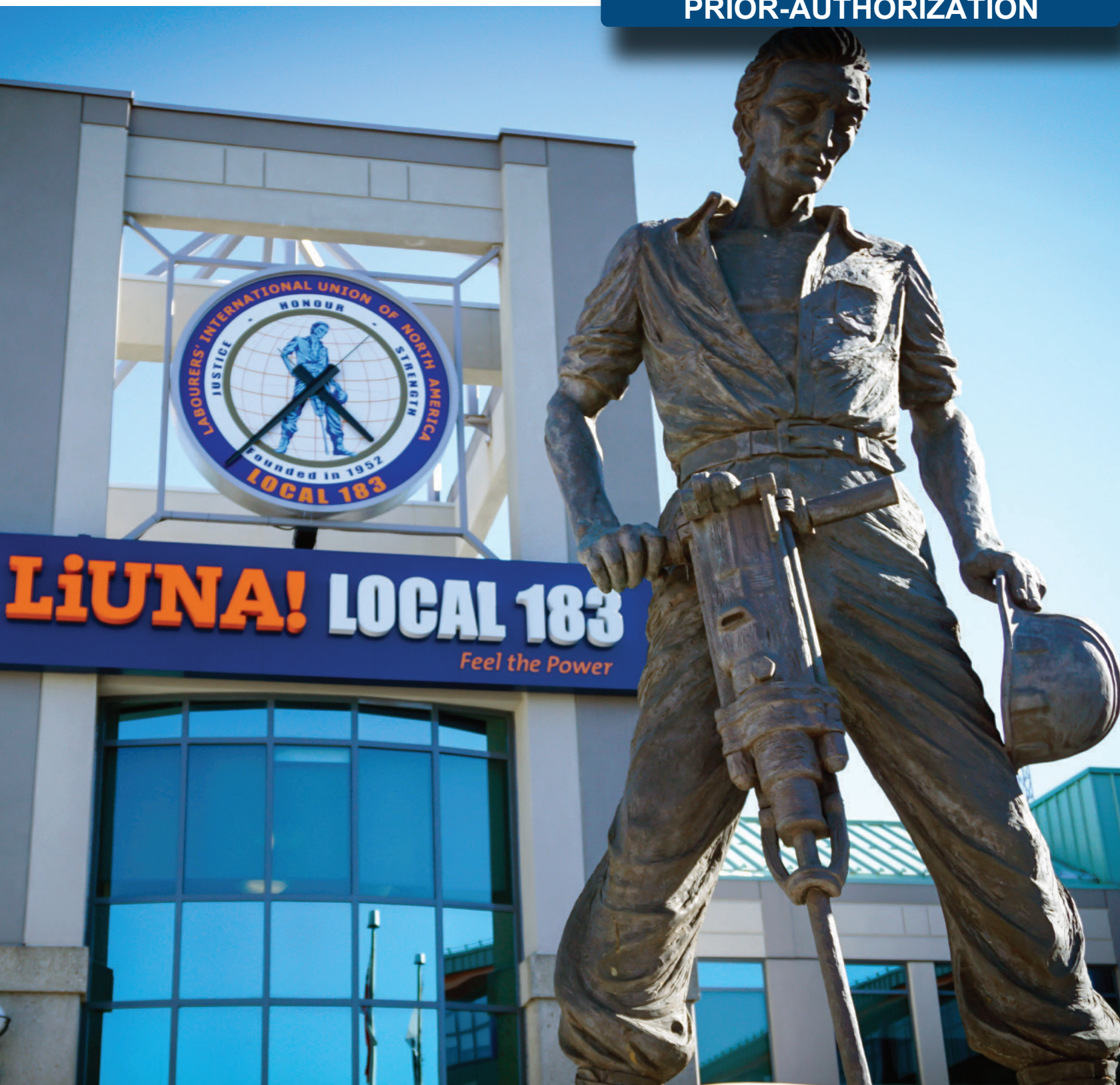
LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

MEDICAL CANNABIS PRIOR-AUTHORIZATION



LiUNAcare Local 183
Email to: info@liunacare183.com
or fax to: 416-240-7488
ATTN: Claims Department

PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
Cannabis for Medical Purposes

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **416-240-7488**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by Patient

Employee or Member Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient Name	Patient Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Member ❑Employee ❑Spouse ❑Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 a.m. and 4 p.m. Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail me at:	❑ Call me (and leave a message if I'm not there) at:	❑ Fax me at:
❑ Contact my Licensed Producer/Seller: Licensed Producer/Seller Name:		Licensed Producer/Seller Phone Number:

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, licensed producer/seller or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

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B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Cannabis		

***Cannabis* will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program**. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies the following criteria:

❑ **Chronic Pain**
- ❑ **Inclusion criteria** (approval period of 12 weeks):
  Patient:
  - ❑ Has refractory neuropathic pain, OR
    - ❑ Has refractory neuropathic pain associated with HIV/AIDS, AND
      - ❑ Is currently receiving optimized antiretroviral therapy, AND
  - ❑ Is ≥ 18 years of age, AND
  - ❑ Has had a reasonable therapeutic trial (6 weeks) of ≥ 3 prescribed analgesics (including as appropriate but not limited to gabapentin, pregabalin, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, and topical capsaicin) and has persistent problematic pain despite optimized analgesic therapy, AND
  - ❑ Has had a reasonable trial (6 weeks) of nabilone or nabiximols (e.g., Sativex) in combination with analgesic therapies and has persistent problematic pain despite optimized analgesic therapy in combination with nabilone or nabiximols, AND
- ❑ Cannabis will be used as an adjunct to other prescribed analgesics, AND
- ❑ Prescriber is a specialist in the management of chronic pain or HIV-associated neuropathy

- ❑ **Renewal Criteria** (approval period of 1 year)
  - ❑ A 12 week trial of cannabis has demonstrated efficacy based on:
    - ❑ Improved analgesia by 2 or more points on a 10-point scale, AND
    - ❑ Improved functioning

OR

❑ **Palliative Care** (approval period of 1 year)
Patient:
- ❑ Is ≥ 18 years of age, AND
- ❑ Requires palliative (end-of-life) cancer pain management, AND
- ❑ Has had a reasonable therapeutic trial of ≥ 2 prescribed analgesics and has persistent problematic pain despite optimized analgesic therapy, AND
- ❑ Has had a reasonable trial of nabilone in combination with analgesic therapies and has persistent problematic pain despite optimized analgesic therapy in combination with nabilone, AND
- ❑ Cannabis will be used as an adjunct to other prescribed analgesics, AND
- ❑ Prescriber is an oncologist or experienced in the use of cannabis in palliative care

OR

❑ **Spasticity** (approval period of 1 year)
Patient:
- ❑ Is ≥ 18 years of age, AND

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Eligibility Criteria

- ❑ Requires treatment for spasticity due to Multiple Sclerosis OR Spinal Cord Injury, AND
- ❑ Has had a reasonable therapeutic trial (6 weeks) of ≥ 2 standard therapies (including but not limited to baclofen, gabapentin, tizanidine, dantrolene, benzodiazepine, or botulinum toxin), and non-pharmaceutical measures (such as daily stretching, range-of-movement exercises) and has persistent spasticity despite optimized standard therapies, AND
- ❑ Has had a reasonable therapeutic trial (6 weeks) of nabiximols (e.g., Sativex) and has persistent spasticity, AND
- ❑ Cannabis will be used as an adjunct to other prescribed standard therapies, AND
- ❑ Prescriber is a neurologist or is otherwise experienced in the use of cannabis in the management of spasticity

OR

❑ **Chemotherapy-Induced Nausea and Vomiting (CINV)** (approval period of 1 year)
Patient:

- ❑ Is ≥ 18 years of age, AND
- ❑ Requires management of refractory CINV, AND
- ❑ Has had a reasonable therapeutic trial (2 cycles total) involving ≥ 2 standard therapies and has persistent CINV. Standard therapies include but are not limited to serotonin antagonists (eg. ondansetron), neurokinin-1 receptor antagonists (aprepitant, fosaprepitant), corticosteroids (dexamethasone), and dopamine antagonists (prochlorperazine, metoclopramide), AND
- ❑ Has had a reasonable therapeutic trial (1 cycle) of nabilone and has persistent CINV, OR
  - ❑ If receiving highly emetogenic chemotherapy, has had a reasonable therapeutic trial (1 cycle) involving 2 or more standard therapies and has persistent CINV. Standard therapies include but are not limited to serotonin antagonists (e.g., ondansetron), neurokinin-1 receptor antagonists (aprepitant, fosaprepitant), corticosteroids (dexamethasone), and dopamine antagonists (prochlorperazine, metoclopramide), AND
- ❑ Has had a reasonable therapeutic trial (1 cycle) of nabilone and has persistent CINV, AND
- ❑ Prescriber is an oncologist or is otherwise experienced in the use of cannabis in the management of CINV

OR

❑ **Anorexia-Cachexia** (approval period of 1 year)
Patient:

- ❑ Requires treatment for anorexia-cachexia associated with cancer, OR
  - ❑ Requires treatment for anorexia-cachexia associated with HIV/AIDS, AND
    - ❑ Is currently receiving highly active antiretroviral therapy, AND
- ❑ Is ≥ 18 years of age, AND
- ❑ Has had a reasonable therapeutic trial of ≥ 1 standard therapies including but not limited to progesterone analogues, corticosteroids, and dietary counselling and continues to experience involuntary weight loss, AND
- ❑ Has had a reasonable therapeutic trial (6 weeks) with nabilone and continues to experience involuntary weight loss, AND
- ❑ Prescriber is an oncologist or experienced in the use of cannabis for cancer, palliative care or HIV/AIDS

Physician Information

Physician's Name	License Number	Telephone Number	Fax Number

Address	City	Province	Postal Code

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Eligibility Criteria	
Physician's Signature	Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __