Please send completed forms to MHCSI:
Fax: 1-902-481-7114 **E-Mail:** professionalservices@mhcsi.ca
Mail: 201 Brownlow Avenue, Unit 20, Dartmouth, NS B3B 1W2

MHCSI PRIOR AUTHORIZATION FORM – ERECTILE DYSFUNCTION (INITIAL REQUEST)

Strictly confidential. This form must be completed in **FULL** and submitted to MHCSI to permit authorization for coverage of a prior authorization medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met and this class of medication is a benefit of your plan. Please contact MHCSI for details of the criteria for these medications. Approvals may be subject to quantity or dollar limits as per plan design.

TO BE COMPLETED BY EMPLOYEE - PATIENT INFORMATION

Member Name :	Group #	Certificate or Client ID #
Mailing Address :	City:	
Province:	Postal Code:	Phone # ( ) Daytime Phone # (if different than above):
Patient Name:		Date of Birth: (DD/MM/YYYY)

Do you or any dependents have other coverage under any other plan ☐ No ☐ Yes **(If Yes, complete the following)**

Name of other Insurer:_____ Member Name: _____

ID #: _____ Policy #: _____

Is this drug covered by coordinating plan? ☐ No ☐ Yes

Are you enrolled in a manufacturer patient assistance program? ☐ No ☐ Yes (program name)_____

*** IMPORTANT, this section of form must be completed in order to avoid processing delays***

You are enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs, Sobeys Pharmacy; Sobeys Pharmacy by Mail, Safeway Pharmacy, FreshCO Pharmacy, Thrifty Foods Pharmacy, Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island.

☐ **My PPN pharmacy location is: _____**

☐ I choose not to use a PPN pharmacy. Reason: _____

Note: Access to some covered specialty medications may be limited to select pharmacy providers.

I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.

Signature (patient 14 yr. and older/parent/legal guardian) **X**	**Date:** (DD/MM/YYYY)

TO BE COMPLETED BY PHYSICIAN – MEDICATION/DIAGNOSTIC INFORMATION FOR INITIAL COVERAGE

Medication Requested:	Dosage & Interval:	DIN:
Quantity Requested:	For Injectables, facility where medication is administered:	
Diagnosis/Indication:	Anticipated length of therapy:	
Therapeutic Goals:		

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TO BE COMPLETED BY PHYSICIAN – CURRENT CLINICAL INFORMATION INITIAL COVERAGE

Criteria

This patient has a confirmed diagnosis of erectile dysfunction (the consistent inability to attain or sustain an erection sufficient for sexual intercourse) due to:

- ☐ Documented side effect from (a) medically necessary prescription medication(s)
  *(Please specify):*_____
- ☐ Diabetes mellitus (on oral hypoglycemic or insulin therapy)
- ☐ Coronary Artery disease
- ☐ Post radical prostatectomy and radiation of the prostate
- ☐ Neurological injury or disease (e.g. Multiple Sclerosis, spinal cord injury)
- ☐ Documented endocrine abnormalities (i.e. low testosterone)
- ☐ Psychiatric disorder for which medication and/or treatment is being received
- ☐ Other (*Please specify):*_____

Prescribing Physician: Please note this patient is enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs; Sobeys Pharmacy; Sobeys Pharmacy by Mail; Safeway Pharmacy; FreshCO Pharmacy; Thrifty Foods Pharmacy Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island.

PRESCRIBING PHYSICIAN	DISPENSING PHARMACIST
Name and Mailing Address: Phone: _____ Fax:_____	Name, Store & Contact Information: Phone: _____ Fax:_____

MHCSI OFFICE USE

☐ Approved Extension Possible ☐ Yes ☐ No ☐ Declined DECLINE CODE:_____	**Notes:**
Date: / Ph.C.:	
Approved Date Range:	
Quantity / Processing Number:	
PPN Only: ☐ Yes ☐ No PPN Dispensing Pharmacy Called: ☐ Yes ☐ No	