

Strictly Confidential
MANAGED HEALTH CARE SERVICES INCORPORATED
PRIOR AUTHORIZATION (PA) FORM

Please Fax form to 1-902-481-7114
 or Mail to: MHCSI, 201 Brownlow Avenue, Unit 20, Dartmouth, NS B3B 1W2

TO BE COMPLETED BY EMPLOYEE

PATIENT INFORMATION

Surname	First Name & Initial	Employee Name (if not patient)
Group #	ID#	Coordination of benefits: <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, Name of Coordinating Plan
Relationship <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	Patient date of birth	If MHCSI, please provide: Group #
Street Address	City	ID#
Province	Postal code	Phone # ()

TO BE COMPLETED BY PHYSICIAN/ NURSE PRACTITIONER/ AND/ OR PHARMACIST
DRUG/DIAGNOSTIC INFORMATION

Medication Requested	Dosage/Dosing Interval	DIN	Quantity Requested
Diagnosis/Indication	Anticipated Duration of Therapy		
Therapeutic Goals			

INFORMATION SUPPORTING REQUIREMENT FOR THIS MEDICATION

Response to Previous Treatment – Medications Tried/Outcomes:

CONTRAINDICATION ADVERSE EFFECT THERAPEUTIC FAILURE OTHER Please explain:

Results of Supporting Lab Tests/ Other Testing (if Applicable)

Alternative Baseline Therapies Not an Option Because: CONTRAINDICATION ALLERGY NOT APPLICABLE OTHER
 Please explain:

PHYSICIAN / NURSE PRACTITIONER		PHARMACIST	
Name(Please Print)		Name(Please Print)	
Signature (If Applicable)	Date	Signature (If Applicable)	Date
Specialty		Store # and Location	
Phone #	Fax #	Phone #	

OFFICE USE ONLY

Approval <input type="checkbox"/> Accepted <input type="checkbox"/> Declined	Date	Quantity
	Approved by	and/or End date

Extension possible Yes No

This form must be completed in full and submitted to MHCSI before non-formulary medications will be covered. Failure to complete this form in its entirety will result in processing delays.