MHCSI
The Pharmacy Benefits Specialists

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: ☐ NO ☐ YES If yes, Name of Coordinating Plan If MHCSI, please provide: Group #
Relationship ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT	Patient date of birth	
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 ☐ Accepted ☐ 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.