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 # __________ ID# ______________________ Is this drug being covered by coordinating plan? ☐ NO ☐ YES
Relationship ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT	Patient date of birth	
Street Address	City	
Province	Postal code	Phone # ( )

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 **X**	**Date (YYYY/MM/DD)**

TO BE COMPLETED BY MEDICAL PRACTITIONER
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:

MEDICAL 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	Approved date range	
		Approved by	Quantity	Processing Number

Extension possible ☐ Yes ☐ No

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