Manulife

Affinity Markets
Medical Marijuana Prior Authorization

1 Instructions

How to complete this form

The purpose of this form is to obtain the medical information required to assess your request for medical marijuana under your drug plan benefit coverage. To avoid delays in processing your request, please ensure that all information, including contact information is complete. Some sections need to be completed by the plan member while others by the health care practitioner. Completion of this form is not a guarantee of approval. All costs incurred to complete this form are the plan member's responsibility.

You need to wait for the prior authorization decision before buying medical marijuana or registering with a licensed producer. If you have the medical document authorizing the use of marijuana for medical purposes from your health care practitioner, you need to keep it with you until you receive further instructions. For clarity, please DO NOT register with a Licensed Producer until you have received further instructions from Manulife or a Manulife-assigned case manager.

2 Plan member and patient information

To be completed by plan member

Plan number	**Identification number**

Plan member name (first, middle initial, last)	Date of birth (DD/MM/YYYY)	Sex assigned at birth ☐ Female ☐ Male

Plan member address (number, street and apt.)	City or town	Province	Postal code

Patient name (first, middle initial, last)	Patient date of birth (DD/MM/YYYY)	Relationship to plan member

Patient's preferred daytime phone number	Patient's email address (optional)

Is the patient covered under any other plan for medical marijuana? ☐ Yes ☐ No

3 Purchased medical marijuana

To be completed by plan member

Has the patient already purchased medical marijuana? ☐ Yes ☐ No

If yes, from which licensed producer was the medical marijuana purchased from?

If the patient has already purchased medical marijuana please attach:

- Invoice showing a breakdown of the charges from the licensed producer
- A copy of the container label or client card issued by the licensed producer

4 Medical information

To be completed by prescribing physician

Product:	**Medical marijuana**
Strain (optional):	
Ratio THC/CBD (optional):	
Dosage grams/day:	
Estimated duration:	

Medical marijuana dosage form: ☐ Dry bud ☐ Oil ☐ Other (please indicate):

4 Medical information (continued)

To be completed by prescribing physician

Please select the diagnosis for which medical marijuana has been prescribed and respond to the corresponding questions.

☐ Spasticity associated with Multiple Sclerosis

For how long has the patient been suffering from spasticity? ______________________

Is the patient currently taking anti-spasticity therapy? ☐ Yes ☐ No

☐ Chronic nausea and vomiting associated with chemotherapy

Has the patient failed to respond to conventional antiemetic treatments? ☐ Yes ☐ No

☐ Chronic neuropathic pain

For how long has the patient been suffering from chronic neuropathic pain? ______________

Is the patient receiving prescription opioids to manage their pain? ☐ Yes ☐ No

Please describe the type and location of your patient's chronic neuropathic pain.

☐ Any other diagnosis

Please provide the specific diagnosis and any Canadian clinical research that supports the use of medical marijuana in your patient's context.

Requests for medical marijuana, if accepted, will be approved for up to a one year time period only. If your patient continues to require this product beyond one year, a new Prior Authorization request needs to be submitted annually.

5 Drug history

To be completed by prescribing physician

For the selected diagnosis, please provide all previous and current drug therapies in the area below.

Drug Name	Please specify the outcome: ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response

Will the patient be continuing this medication in addition to new therapy? ☐ Yes ☐ No

For how long did the patient take this medication? (specify duration)______________________

Drug Name	Please specify the outcome: ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response

Will the patient be continuing this medication in addition to new therapy? ☐ Yes ☐ No

For how long did the patient take this medication? (specify duration)______________________

Drug Name	Please specify the outcome: ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response

Will the patient be continuing this medication in addition to new therapy? ☐ Yes ☐ No

For how long did the patient take this medication? (specify duration)______________________

6 Physician information

To be completed by prescribing physician

Prescribing physician's name	Specialty	Telephone Number	Extenstion

Address (number, street and suite)	City or town	Province	Postal code

7 Physician authorization

To be completed by prescribing physician

I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in an Affinity Markets health file with Manulife Financial and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Physician's signature	Date signed (DD/MM/YYYY)

Your patient needs to wait for the prior authorization decision before buying medical marijuana or registering with a licensed producer. Your patient needs to keep their medical document authorizing the use of marijuana for medical purposes until they receive further instructions.

8 Plan member signature and authorization

To be signed by plan member

I confirm that:

- I, or one of my family members covered by my plan, need the drug named on this form (or an equivalent drug that Manulife proposes)
- the information I have given you in this request is true and complete

I agree that Manulife can collect, use, keep, and share my personal information, or the personal information of my family members, to manage this claim.

I agree that Manulife can also use this information for these purposes:

- managing my plan
- assessing and processing claims
- investigating and ensuring the quality and accuracy of claims
- patient assistance programs, if they apply

I agree that these people and groups can share my personal information with Manulife to manage my claim:

- medical and health professionals, such as my doctor, Manulife's doctor, pharmacist and nurse
- health providers, such as pharmacies, preferred pharmacies, hospitals, clinics, patient assistance programs
- Manulife's service providers

If my Manulife plan requires me to buy a drug that needs prior authorization from a preferred pharmacy or provider, a case manager may contact me, my doctor and/or Patient Assistance Program to:

- give me information about the program
- arrange to have my prescription or authorization transferred to the preferred pharmacy or provider

I agree that a photocopy or electronic version of this authorization is valid.

Protecting your personal information is important to us. People who can see your personal information are:

- Manulife employees who need to see your information to do their jobs
- people you've given permission to

To find out more about Manulife's privacy policy please see manulife.ca.

Plan member's signature	Date signed (DD/MM/YYYY)
Patient's signature	Date signed (DD/MM/YYYY)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

9 Mailing instruction

Manulife Affinity Markets
Health Claims
P.O. Box 670, Stn Waterloo
Waterloo, ON N2J 4B8
Fax: 1-800-987-0627

Please retain a photocopy for your files.