MEDICAL CANNABIS
SPECIAL AUTHORIZATION REQUEST FORM

Please note: Incomplete and/or missing information may delay your request for processing.

SECTION 1 – PATIENT INFORMATION

Surname	Green Shield I.D. #	Employer Name
First Name	Date of Birth (Y/M/D)	Telephone Number
Street Address	City Province	Postal Code

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, clinic or medically related facility, to give to Green Shield Canada information regarding my health. I hereby authorize Green Shield Canada to exchange information with other parties as required, only when the information is needed to administer this benefit and/or to confirm the accuracy of this information.

Date ______________________________ **Signature of Patient** ______________________________

(If under 16 years of age, the signature of the plan member is required.)

SECTION 2 – PRESCRIBER INFORMATION

Prescriber Name	Prescriber Signature	Specialty	Date (Y/M/D)
Street Address		Telephone Number	
City Province Postal Code		Fax Number	

SECTION 3 – DRUG REQUESTED FOR EVALUATION

*****Medical cannabis will only be eligible if purchased/dispensed by a Health Canada approved supplier*****

☐ **For the management of multiple sclerosis-related spasticity in adults 25 years of age or older after an adequate trial of at least two prior therapies and Sativex® (delta-9- tetrahydrocannabinol and cannabidiol).**

Prior treatment:

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☐ **For the management of severe nausea and vomiting associated with moderately or highly emetogenic cancer chemotherapy in adults 25 years of age or older despite optimal management with antiemetic therapy (demonstrated during at least two cycles) AND failure following an adequate trial of nabilone.**

Prior treatment: ____

Projected completion date of last chemotherapy cycle: ______________________________

****Consideration for reimbursement will only be made for remaining chemotherapy cycles in current regimen.**

☐ **For the management of chronic NEUROPATHIC pain in adult patients 25 years of age or older following failure of an adequate trial of 1) opioid analgesic, AND 2) nabilone, AND 3) and two or more of the following: a gabapentinoid, tricyclic antidepressant, or serotonin noradrenaline reuptake inhibitor. Consideration will be made for patient specific contraindications.**

Diagnosis: ____

1) **Prior opioid trial:**
   Medication: _________________________ **Timeframe:** _________________ **Result:** _____________________

2) **Prior nabilone trial:**
   Medication: _________________________ **Timeframe:** _________________ **Result:** _____________________

3) **Prior gabapentinoid, tricyclic antidepressant, or serotonin noradrenaline reuptake inhibitor trials (must have tried two):**
   Medication: _________________________ **Timeframe:** _________________ **Result:** _____________________
   Medication: _________________________ **Timeframe:** _________________ **Result:** _____________________

☐ **For an add-on treatment in patients with diagnosed Dravet Syndrome or Lennox-Gastaut Syndrome with daily seizure frequency after failure of two appropriately prescribed and utilized anti-seizure medications.**

Prior treatment:

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****Reimbursement will not be considered for patients under 2 years of age, except under exceptional circumstances in which a detailed letter outlining the rationale is provided.**
****Reimbursement for this indication will be for CBD products only (no THC component).**

Additional comments pertaining to above: ____

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Please provide us with information on other coverage (provincial or private) as it pertains to this patient and medication:

Applied for coverage: ☐ Yes ☐ No ☐ Approved ☐ Denied

SECTION 4 – MAILING INSTRUCTIONS

Once completed, return request form along with any original paid “Official Pharmacy” receipts to:

Green Shield Canada, Drug Special Authorization Department,
P.O. Box 1606, Windsor ON N9A 6W1
Forms can be faxed or emailed: Fax: 1.519.739.6483 or Toll Free: 1.866.797.6483 or Email: drugspecial.autho@greenshield.ca

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.