Facet

Therapeutic Class Pricing Exemption Form

To apply for an exemption, please complete page 1 and have your physician complete page 2. Completion of this form is not a guarantee of approval. All costs incurred to complete this form are the plan member's responsibility.

PART 1: PATIENT INFORMATION		
Patient Name:	**Plan Member** Name:	
Patient Date of Birth (YYYY/MM/DD):	**Plan Member** Date of Birth (YYYY/MM/DD):	
Plan Sponsor/Employer:	Plan Group/Contract Number:	Certificate/ID Number:
Patient's relationship to the covered member: ☐ Spouse ☐ Dependant	Preferred language of communication: ☐ English ☐ French	
Patient E-mail: ______________________	Patient Phone Number: ______________________	
Patient Address: ______ Number ______ Street ______ City ______ Province ______ Postal Code		
Preferred method of communication with FACET about any and all claim(s), including prior and subsequent claim(s). If you select email, you agree and accept that email may contain medical information and that the security of email can never fully be guaranteed: ☐ E-mail ☐ Mail		

PART 2: CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

As of the date hereof, I hereby authorize any person or organization who has personal health information about me, including any health care professional (which includes but is not limited to physicians, medical specialists, physiotherapists, pharmacists or any other person who has examined or treated me), health care institution, pharmacy patient support program, and other medical-related facility, and any authorized agent of mine to release and disclose to Cubic Health Inc. ("Cubic"), the company that runs the FACET Program, any personal information regarding my past medical history and current medical condition, including any relevant clinical notes (collectively, the "Personal Health Information"), which may be required to adjudicate the Request for Prior Authorization to which this Consent forms a part (the "Request").

I understand and agree that Cubic will keep any Personal Health Information obtained from such persons, organizations and/or agents secure and confidential and in accordance with applicable legislation and that my Personal Health Information will not be shared with any other party with the exception of the insurance carrier for adjudication or processing of prescription claims, the plan's preferred pharmacy/provider network for dispensing/distribution when required, and the relevant Patient Support Program to facilitate medication access when required.

I authorize Cubic to collect, use and maintain my personal information, such as name, address, email address, and the Personal Health Information it deems necessary, for the purposes of adjudicating the Request or any purposes in any way ancillary thereto. I authorize Cubic to collect, use and disclose my personal information in accordance with its Privacy Policy located at: https://www.facetprogram.ca/en/privacy/.

I hereby acknowledge and understand that:

- access to and disclosure of my Personal Information will be limited to Cubic pharmacists and other Cubic employees in the course of their employment with Cubic, the insurance carrier, the plan's preferred pharmacy/provider network (if applicable), and the Patient Support Program (if applicable);
- all communication regarding the patient and their Request will be made through the e-mail and phone number provided on the Request;
- any cost(s) associated with the completion of this form is my responsibility to pay;
- by filling out the Request, I am not guaranteed approval for any level of coverage;
- Cubic is an independent clinical review panel and is not affiliated with my employer, plan sponsor, plan administrator or insurance company and that Cubic has been engaged for the purpose of ensuring that criteria for the approval of claims are satisfied before approval is granted, and to ensure that the criteria for coverage are implemented consistently;
- Cubic specifically assumes no responsibility for the completeness or accuracy of any Personal Information which may be provided to Cubic in connection with the Request, and Cubic disclaims all liability for any loss or damage suffered by any person, including (without limitation) me, as a result of the processing or outcome of the Request;
- I have no claim against Cubic for any loss or damage (direct, indirect, incidental, consequential or otherwise) I may suffer as a result of the handling, processing or outcome of the Request;
- This consent will remain in effect for this and any future related Request(s) for Prior Authorization under my drug benefit plan, unless and until it is revoked in writing. Providing this consent is voluntary, and I may withdraw it at any time by notifying Cubic in writing, subject to any applicable legal or contractual limitations.

I understand and agree to the terms above. *(If the patient is a minor, a parent/guardian must sign below. For the purposes of this consent form, a minor is defined as any person who is under the legal age of majority in their province or territory of residence).*

______________________ ______________________ ______________________

Patient Full Name (please print) Patient Signature Date Signed (YYYY/MM/DD)

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PART 3: PRESCRIBER INFORMATION		
Physician Name:	Speciality:	Registration Number:
Address:		
Fax Number: ______________________________ *(required)*	Phone Number: ______________________________	

PART 4: MEDICATION REQUESTED FOR EXCEPTION	
Drug Name requested:	DIN:
Dosage and frequency prescribed:	
Diagnosis / Indication for treatment:	

Please indicate the clinical reason(s) for requesting an exception for this medication:

- ☐ Adverse drug reaction (allergy or intolerance) to the reference drug product(s) (complete Part 5)
- ☐ Inadequate clinical response (therapeutic failure) to the reference drug product(s) (complete Part 5)
- ☐ Presence of patient-specific factors that preclude the use of the reference drug product(s) (specify and complete Part 6 below):

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PART 5: PREVIOUSLY TRIED THERAPIES

List all previously tried brand-name and/or generic products below. For each of the products tried, please include the medication name, manufacturer, DIN, dosage regimen prescribed, timeline of use, and details of intolerance or therapeutic failure.

Product #1		
Medication Name:	Manufacturer:	DIN:
Dosage/frequency prescribed:	Dates trialed: ________________ to: ________________	
Outcome: ☐ Adverse Drug Reaction (allergy, intolerance) ☐ Therapeutic failure	Description:	

Product #2		
Medication Name:	Manufacturer:	DIN:
Dosage/frequency prescribed:	Dates trialed: ________________ to: ________________	
Outcome: ☐ Adverse Drug Reaction (allergy, intolerance) ☐ Therapeutic failure	Description:	

PART 6: OTHER CLINICAL INFORMATION

For patients requesting an exception for reasons other than adverse drug reactions or therapeutic failures to alternative versions of the medication, please provide detailed information to support why an exception should be made for the drug requested.

Please be advised further information may be requested if needed to facilitate determination of coverage.

I hereby certify that the information provided is true, correct, and complete.

______________________________________ ______________________________

Prescribing Physician's Signature Date Signed (YYYY/MM/DD)

Please submit the completed form to FACET by:

Fax: 1-844-446-1575 **E-mail:** claims@facetprogram.ca

Questions? Please call FACET at 1-844-492-9105