HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

Pharmacare Tie-In Questionnaire

In order for us to assist you with your drug coverage problems please complete this two-page questionnaire and release in full. **Until we have your full information and authorization we are unable to act on your behalf.**

Name: ____

Home Address: ____

Phone Number(s): __________________________ **Personal Email:** _________________________

Employer: _________________________________ **Worksite:** _____________________________

Drugs which are not being covered:

(Please specify if drug is for a dependent and if so include dependent ID number eg: 01,02,03. For additional entries please include in the Other/Additional information section of this questionnaire)

Name: ________________________ **DIN** ______________ **PBC Dependent #** __________________

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Date your physician applied for Special Authority in order for the drug(s) to be covered:
Date: __________________ ☐ Physician has not requested Special Authority from Pharmacare

Was Special Authority for the medication(s) denied by Pharmacare?
Yes ☐ **No** ☐ **I don't know** ☐

Medication(s) denied Special Authority: ____
What reasons were given that Special Authority was denied?
(see Special Authority form for details and provide a copy of the denied SA form)
____

If you have already received Special Authority approval from PharmaCare, please confirm that you have:
☐ Submitted written confirmation of Special Authority approval to Pacific Blue Cross (PBC)
Date submitted: _________________________
☐ Followed up with Pacific Blue Cross to ensure that the Special Authority approval have been received and processed. Date the Special Authority was received: _____________ Processed: ________________

Other/Additional information: ____
____
____
____

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Authorization for release of medical and/or personal information

TO: Health Sciences Association
300-5118 Joyce Street
Vancouver, BC V5R 4H1

RE: **Name of plan member:** ____________________

Employer: ____________________

Pacific Blue Cross (PBC) Group Plan Number: ____________________

Personal Identification Number: ____________________

Dependent(s) full name and PBC dependent number (s):
Please provide this information ONLY if the drug(s) concerned is taken by your dependent(s)

____

____

Prescription drug(s): ____________________

This is to authorize representatives of Health Sciences Association of BC to release medical and/or personal information to the Health Employers Association of BC (HEABC), Healthcare Benefit Trust (HBT) and/or Pacific Blue Cross (PBC) in acting on my behalf to resolve my or my dependent's drug coverage issues with HEABC, HBT and/or PBC.

The medical and/or personal information provided to HSA is for the sole purpose of investigating and resolving my or my dependent's concerns with respect to the Pharmacare Tie-In implementation and not for any other purpose.

This authorization does NOT provide HEABC, HBT and/or PBC with the authority to disclose or discuss my or my dependent's medical and/or personal information with my employer.

A duplicate or photocopy of this original shall be as good as an original.

____________________ ____________________

Member's signature Date