UNIFOR- FORD HEALTH CANNABIS BENEFIT
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** _____

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*

****All requests for medical cannabis will only be considered for adults aged 25 years or older ****

Has the patient completed education on medical cannabis usage through the Canabo Medical Clinic?

☐ **Yes** ☐ **No**

****Education through the Canabo Medical Clinic must be completed for approval****

Please indicate the diagnosis being treated:

- ☐ **Chronic social or generalized anxiety**
- ☐ **Insomnia**
- ☐ **Chronic pain**
- ☐ **Epilepsy**

****The prescriber must fully complete the section below pertaining to the above medical condition****

Chronic social or generalized anxiety:

For the management of chronic social or generalized anxiety disorder in patients who have failed at least one prior SSRI/SNRI agent AND at least one other anxiolytic/antidepressant agent.

Disease severity according to GAD-7: _____
Duration of disease: _____
Prior treatment: _____
_____

Insomnia:

For the management of chronic insomnia in patients who have failed at least one prior sedative/hypnotic agent.

Has CBT been tried and/or sleep hygiene strategies been reviewed with the patient? ☐ **Yes** ☐ **No**
Has this patient been evaluated for sleep apnea? ☐ **Yes** ☐ **No**

Prior treatment: _____

_____

****Both questions above must be affirmative to qualify for coverage****

Chronic pain:

For the management of chronic pain in patients who have failed at least two prior non-opioid analgesics.

Duration of disease: _____
Prior treatment: _____

_____

Epilepsy:

As an add-on treatment in patients with epilepsy after failure of two appropriately prescribed and utilized anti-seizure medications.

Prior treatment: _____

_____

Additional comments pertaining to above:

_____

_____

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.