Pharmacy Confirmation – OHIP+ Transition of Claims Requiring Prior Authorization

Where OHIP+ has previously paid claims for a drug,

1. submit the claim electronically to the insurer on or after April 1, 2019 to determine if Prior Authorization (PA) is required.
2. If required, complete this form, **print and affix patient receipt**, showing payment of this drug by OHIP+ (dated prior to April 1, 2019) and return to the patient for submission to their insurer.
3. Please allow time for processing. Submission of this form is not a guarantee of coverage.

DATE: ____

Section 1: To be completed by Pharmacist:

Drug Name and DIN number:	Drug Dosage and frequency:
EAP Expiry date (OHIP+) for this drug (if known):	Signature of Pharmacist:
Pharmacy Telephone Number:	Carrier No:
Policy or Group number:	Certificate number:

Section 2: To be completed by Plan Member or Pharmacist:

Patient's Name (First, Last)	Patient's Date of Birth (DD/MM/YYYY)
Plan Member's Name (First, Last)	Signature of Patient/Guardian:
Plan Member Signature:	Relationship to Patient: (member/spouse/dependent)
Are you enrolled in a Patient Support Program? ☐ Yes ☐ No * If yes state which program:	

Affix patient receipt here.

ONTARIO PHARMACISTS ASSOCIATION
Advocating Excellence in Practice and Care

This form was developed by the Canadian Life and Health Insurance Association (CLHIA) for purposes of OHIP+ for Children and Youth, March 2019