Facet

Prior Authorization Appeal Form

A decision to not approve the originally requested specialty drug may be appealed using this form. This form must be completed by a physician and include all relevant information in support of the patient's appeal. The completion of this form does not guarantee a successful appeal. All costs incurred to complete this form are the plan member's responsibility.

The rationale(s) cited in the original decision to decline the requested drug regimen must be addressed within this appeal.

PATIENT INFORMATION	
Patient Name:	Patient Date of Birth (YYYY/MM/DD):
Policy/Plan Number:	Certificate Number:

APPEAL – CLINICAL INFORMATION (to be completed by prescribing physician)
Reason for appeal (please select all that apply):
□ Confirmed Allergy / Contraindication *Please describe the nature of the intolerance or contraindication to the therapeutic alternatives for the originally requested medication.
□ Underlying medical condition has changed/progressed *Please attach relevant lab results and clinical notes in support of the appeal, if applicable.
□ New / unconsidered clinical trial data *If the appeal is based on clinical trial data, please attach a copy of the journal article and indicate the rationale here.
□ Other (please specify): _____

Please attach additional information as needed.

_____ _____

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

Please submit the completed form by:

Fax: 1-844-446-1575

Email: appeals@facetprogram.ca