LiUNA!care
LOCAL 183™
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

MEDICAL CANNABIS PRIOR-AUTHORIZATION

Medical Cannabis Prior Authorization Form

The purpose of this form is to obtain medical information required for the assessment of your claim.

Note: This form must be completed by both the patient and the physician. All fields are mandatory. Incomplete forms may result in the application being declined. Please retain a copy of this form for your records.

Please allow three business days for a response once all information is received and complete.

Notification of the results of this request will occur Monday to Friday between 9 a.m. and 4 p.m. Eastern Time.

Cannabis prior authorizations are valid for 365 days from the date of approval. A new Prior Authorization request is required after this date.

Instructions

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The member must complete **Section A**.
3. The physician must complete **Sections B, C, D, E, F**. The member is responsible for any costs associated with completing this form.
4. Return the completed form to:

   LiUNAcare Local 183
   Email to: info@liunacare183.com
   Fax to: 416-240-7488
   Attention to: Claim Department

5. For any questions about the program, or the status of your Prior Authorization form, please contact **LiUNAcare Local 183**.

LiUNAcare Local 183 | 200 Labourers Way, Suite 2100, Vaughan, ON L4H 5H9
Phone **(416)-240-7487** | Fax **(416)-240-7488** | Email **info@liunacare183.com** | **liunacare183.com**

Member Information - Section A:

Information to be Completed by Member	
Member Name	
Benefit Card Number	
Claimant Name	
Claimant Date of Birth (DD/MMM/YYYY)	_____ / _____ / _____
Relationship to Member	□ Member ☐ Spouse ☐ Dependent

Member/Claimant Consent and Request for Medical Cannabis Coverage

By signing below, I certify that the information provided by me is true, correct, and complete to the best of my knowledge. I authorize LiUNAcare Local 183, insurance companies, their authorized representatives, agents, and service providers to use and exchange this information needed for underwriting, administration, and paying claims with any person or organization who has relevant information on this claim, including health professionals, institutions, and investigative agencies in the event of an audit. I authorize LiUNAcare Local 183, the insurance companies, their authorized representatives, and agents to contact any licensed physician, institution, licensed producer/seller, or person who has any records or knowledge of me or my health with respect to this submitted prior authorization form.

I acknowledge that I have discussed the use of medical cannabis with my physician and consent to the submission of this prior authorization form to LiUNAcare Local 183, the insurance companies, and their authorized representatives, and I hereby request coverage for the use of medical cannabis as part of my prescribed treatment plan. I understand that coverage is subject to review and approval by LiUNAcare Local 183, the insurance companies, and their authorized representatives, I consent to the submission of this request to my insurance provider for consideration.

Member Signature: _____

Date (DD/MMM/YYYY) | _____ / _____ / _____

Preferred Method of Contact (select one):

□ **Email:** _____

□ **Telephone:** _____

□ **Fax:** _____

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Criteria - Section B:
Please indicate if the patient meets the following:
(to be completed by Prescribing Physician) (check all relevant items)

☐ **Chronic Pain (approval period of 1 year) (check all relevant items) :**
- □ Has refractory neuropathic pain
- □ Has refractory neuropathic pain associated with HIV/ AIDS
- □ Is currently receiving optimized antiretroviral therapy
- □ Is ≥ 18 years of age
- □ Has had a reasonable therapeutic trial (6 weeks) of 2-3 prescribed analgesics (e.g., gabapentin, pregabalin, SNRIs, TCAs, topical capsaicin) with persistent problematic pain
- □ Has had a reasonable trial (6 weeks) of nabilone or nabiximols (e.g., Sativex) in combination with analgesic therapies with persistent pain
- □ Cannabis will be used as an adjunct to other prescribed analgesics
- □ Prescriber is a specialist in the management of chronic pain or HIV-associated neuropathy
- □ Initial diagnosis date (dd/mm/year) _____
- □ Anticipated duration of treatment _____

☐ **Palliative Care (approval period of 1 year) (check all relevant items) :**
- □ Is ≥ 18 years of age
- □ Requires palliative (end-of-life) cancer pain management
- □ Has had a reasonable therapeutic trial of 2 prescribed analgesics with persistent problematic pain
- □ Has had a reasonable trial of nabilone in combination with analgesic therapies with persistent pain
- □ Cannabis will be used as an adjunct to other prescribed analgesics
- □ Prescriber is an oncologist or experienced in the use of cannabis in palliative care

☐ **Spasticity (approval period of 1 year) (check all relevant items) :**
- □ Is ≥ 18 years of age
- □ Requires treatment for spasticity due to Multiple Sclerosis OR Spinal Cord Injury
- □ Has had a reasonable therapeutic trial (6 weeks) of 2 standard therapies (e.g., baclofen, gabapentin, tizanidine, dantrolene, benzodiazepine) and non-pharmaceutical measures (e.g., daily stretching) with persistent spasticity
- □ Has had a reasonable therapeutic trial (6 weeks) of nabiximols (e.g., Sativex) with persistent spasticity
- □ Cannabis will be used as an adjunct to other prescribed standard therapies
- □ Prescriber is a neurologist or experienced in the use of cannabis in the management of spasticity

☐ **Chemotherapy-Induced Nausea and Vomiting (CINV) (approval period of 1 year) (check all relevant items) :**
- □ Is ≥ 18 years of age
- □ Requires management of refractory CINV
- □ Has had a reasonable therapeutic trial (2 cycles) of 2 standard therapies (e.g., serotonin antagonists, corticosteroids) with persistent CINV
- □ Has had a reasonable therapeutic trial (1 cycle) of nabilone with persistent CINV
- □ Prescriber is an oncologist or experienced in the use of cannabis in the management of CINV

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☐ **Anorexia-Cachexia (approval period of 1 year) (check all relevant items) :**

- ☐ Requires treatment for anorexia-cachexia associated with cancer OR HIV/AIDS
- ☐ Is currently receiving highly active antiretroviral therapy (if HIV/AIDS
- ☐ Is ≥ 18 years of age
- ☐ Has had a reasonable therapeutic trial of 1 standard therapy (e.g., progesterone analogs) with continued involuntary weight loss
- ☐ Has had a reasonable therapeutic trial (6 weeks) with nabilone with persistent weight loss
- ☐ Prescriber is an oncologist or experienced in the use of cannabis for cancer, palliative care, or HIV/AIDS 4

Prescription Details - Section C:
(to be completed by Prescribing Physician)

Medical Cannabis Prescription Details	
Formulation	☐ Oil ☐ Capsule ☐ Other: _____
THC Content (%)	
CBD Content (%)	
Dosage (e.g., mg/day)	
Method of Administration (e.g., oral, vaporized, etc.)	
Duration of Treatment (e.g., 3 months, 6 months, etc.)	
Refill Frequency	☐ Monthly ☐ Quarterly

Supporting Documentation - Section D

Attach the following documentation to support this request (if applicable) :

- ☐ Clinical notes and medical history
- ☐ Diagnostic test results
- ☐ Previous treatment records
- ☐ Any additional supporting documentation

Prescribing Physician - Section E:
(to be completed by Prescribing Physician)

Prescribing Physician	
Physician's Name	
License Number	
Facility/Clinic Name	
Address	
City	
Province	
Postal Code	
Phone Number	
Fax Number	
Email Address	

Authorization and Consent - Section F:

By signing below, I affirm that the information provided is accurate to the best of my knowledge and that I have prescribed medical cannabis as part of the patient's treatment plan. I understand that LiUNAcare Local 183, the insurance carrier, and their authorized representatives may request additional information to process this prior authorization.

Cannabis will be eligible for reimbursement only if the patient satisfies the conditions of the benefits program and if the patient does not qualify for coverage under any other drug plan or government-mandated program. If the patient is covered under another drug plan or government-mandated program, the prior authorization program, as part of the benefits plan, may cover only the portion not paid for by the primary plan.

Prescribing Physician Signature: _____

Date (DD/MMM/YYYY) |_____ / _____ / _____

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Internal Provider Information - Section H:

Provider Use Only	
Date Received **(DD/MMM/YYYY)**	
Authorization Number	
Category	☐ Category 1 — Prior History of pain medication
	☐ Category 2 — No history of pain
Decision	☐ Approved ☐ Denied ☐ Additional Info
Comments/Notes	

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